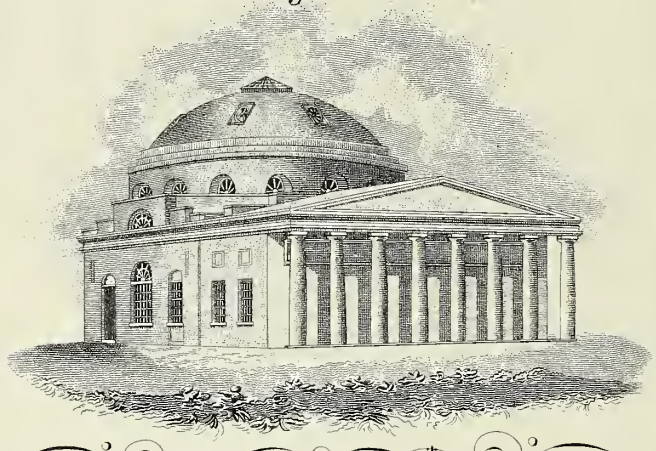
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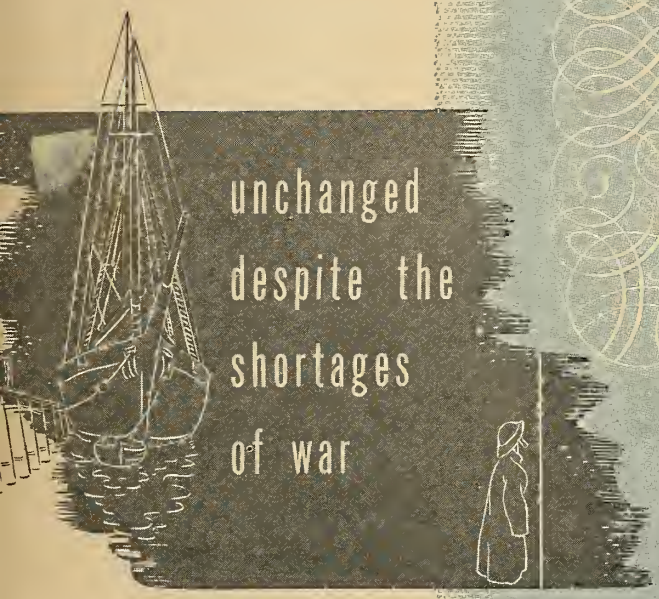
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FIRST TO LEAP



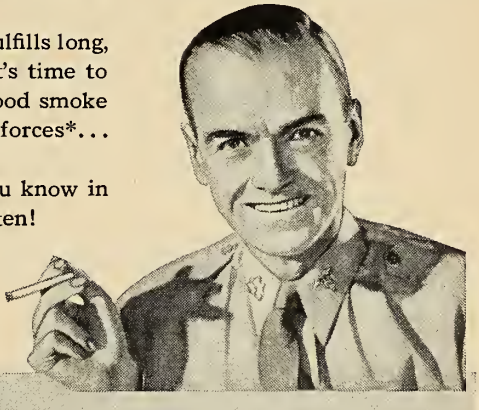
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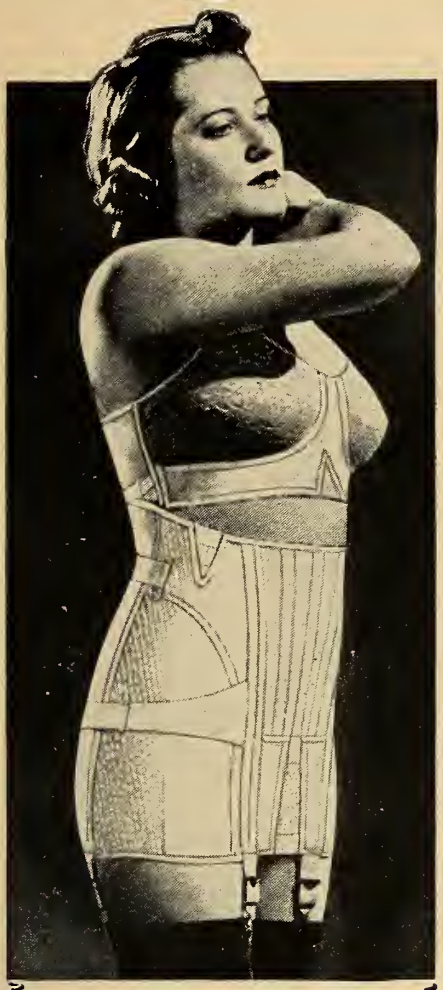
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WAR BULLETINS

THE FEDERAL PLAN FOR PROVIDING OBSTETRIC AND PEDIATRIC CARE FOR WIVES AND INFANTS OF SERVICEMEN

L. FERNALD FOSTER, M.D.
Secretary Michigan State Medical Society
Bay City, Michigan

When asked to prepare a paper relative to the Children's Bureau plan of providing obstetric and pediatric care for the wives and infants of servicemen, it was very apparent that any presentation given at this time could be only one of reporting observations and views as gathered from various physicians throughout the country. Each State Association represented here today has probably taken some action relative to this subject:—either having accepted the plan as presented, rejected it in toto or accepted it with modifications. A discussion of the plan a year ago, when some uniformity of action might have been developed, would probably have been more apropos.

The history and background of the Children's Bureau plan is well known to everyone present and needs no reiteration today. It might not be amiss, however, to refresh our memories on the action of the American Medical Association House of Delegates taken in June, 1943, on this subject, which approved the reference committee's recommendations that—

(a) The action of the Federal Government in making funds available for maternity and infant care for the wives and infants of enlisted men be approved, and that

(b) the adoption be urged of a plan under which the Federal Government will provide for the wives of enlisted men a stated allotment for medical, hospital, maternity and infant care, similar to the allotments already provided for the maintenance of dependents, leaving the actual arrangements with respect to fees to be fixed by mutual agreement with the wife and the physician of her choice.

The war emergency offered a good opportunity for the proponents of the present program to utilize the great interest appeal of Maternal and Child health for the families of servicemen. Is this project, embracing a small segment of medical practice, being utilized as a trial balloon for complete federalization of medical practice?

Are the proponents of a plan of complete Federalized Medical Care watching the attitude of the medical profession toward this plan in order to determine what their activities shall be—either to make bolder strides toward their totalitarian objective, or to retreat from their grandiose scheme?

Many physicians question the sincerity of purpose in this program. In the first place they are suspicious of this measure which was enacted not as a legislative proposal but as an amendment slipped into an important appropriation act. They further suspect sharp practice in the wholesale premature presentation of the program to the thousands of servicemen in camps *before* the matter was even presented to the necessary purveyors of the services, the doctors. Physicians resent the modern method of "legislation by edict" as exemplified in the Children's Bureau's ruling that payments cannot be made to the servicemen's wives but shall be made direct to physicians. Many physicians say that the published reports of approval by some two-score of states are misleading in that the plan approved was in many instances that of the State Health Department and not of the Medical Profession of the State.

These physicians feel that no program, no matter how worthy, can be successful if founded on bad faith and lack of mutual trust.

In our own state we were promised by the Director of Maternal Health and Child Welfare that no "Michigan Plan" would be presented to the Children's Bureau until the Executive Committee of our Council met and took action. The meeting of this committee was scheduled for May 20, 1943. The Children's Bureau, however, announced that a "Michigan Plan" was approved on May 12, 1943, and a newspaper release of May 17 gave the announcement nationwide publicity. This experience can scarcely be called good faith.

Obviously our Health Departments have little to say in the matter of policies in this matter. On the occasion of the meeting of the House of Delegates of the Michigan State Medical Society held in Detroit in September, our Health Commission very graciously agreed to practically all the proposals of the delegates and we felt a difficult problem was being readily solved. Within one hour of the Health Commissioner's acquiescence a five-page day-letter was received from the Children's Bureau and his every promise was repudiated before the same House of Delegates.

The following day Dr. Dailey of the Children's Bureau appeared before the Council of the State Medical Society and made it quite clear that the only acceptable plans were those containing the features objectionable to the medical profession—features which are wholly bureaucratic edicts.

(Continued on Page 10)

Read before the Annual Conference of Secretaries of the Constituent State Medical Societies of the American Medical Association, Chicago, November 20, 1943.



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WAR BULLETINS

(Continued from Page 8)

The main objection to the program is expressed in the American Medical Association resolution: payment direct to doctors of medicine. Everyone, including the dependents themselves, would favor a program based on allotments to servicemen's dependents. There appears to be nothing in the law (the brief amendment to the appropriation act) that specifically prohibits payments to servicemen's families. The present refusal of the Children's Bureau to try such an arrangement is based on a mere legal opinion.

Further serious objection lies in the fact that the plan does not take into consideration obstetric complications, emergencies and compensation commensurate with care demanding special technical skill. Such lack of consideration would tend to lower the quality of care —which is one of the most serious objections to all schemes of Federalized medicine. Considerable objection has also been had to the very meagre provisions made for pediatric services.

The actual need for such a broad program as the present project promises to be is questionable. However, the widespread publicity given the plan has definitely stimulated a big demand. The bait of "something for nothing" is always alluring to the unthinking populace. It is incomprehensible to the average American that his wife and children's free obstetric and pediatric care may lead to complete regimentation of medicine which in itself may be the entering wedge for the general socialization of the country.

Experience has shown in many cases that where the doctor has had the time to explain the implications of this scheme to his patients they prefer to remain as private patients instead of wards of the Federal Government.

Doctors in those states which have refused to approve the plan in its present form are concerned over the position of those State Medical Associations which have endorsed officially the Federal program of Obstetric and Pediatric care. They have established a precedent which is not consistent with their general opposition to complete State Medicine. This action by State Associations is being utilized to good advantage by representatives of the Children's Bureau in their attempts to influence other states to adopt the program. It has helped to make the stand of some State Associations extremely difficult and almost hopeless.

In our own state (Michigan) the House of Delegates took the following action last September:

(a) "Because this plan is a form of State Medicine the Michigan State Medical Society refuses to coöperate in any of the provisions of the plan in its present form."

(b) "That until satisfactory adjustments in the program can be made the members of the Michigan State Medical Society are requested to give professional care gratis in order that the wives and children of servicemen may obtain hospital care."

My attention has been invited to a resolution passed by the Executive Board of the American Academy of Pediatrics, as follows:

> WHEREAS, the Executive Board of the American Academy of Pediatrics meeting in full executive session at the Palmer House in Chicago on November 6, 1943, is in complete sympathy with the objective that the wives and infants of servicemen should receive the best quality of obstetric and pediatric care during the present emergency, and
>
> WHEREAS, the Children's Bureau has inaugurated plans and regulations to carry out the intent of Congress to provide a high type of medical care for the wives and children of our men in the armed services, and
>
> WHEREAS, the present administrative regulations as set up by the Children's Bureau have, in the application of the program, revealed certain weaknesses which seriously interfere with securing such high type of medical care for wives and infants of servicemen,
>
> BE IT RESOLVED, that in order to attain the high quality of medical service to which the wives and children of servicemen are entitled, it is the sense of this Board that the Children's Bureau should call, forthwith, a conference of official representatives of the servicemen, together with official representatives of the professions actually rendering this service, namely, the American Medical Association, the American Hospital Association, the U. S. Public Health Service, the American Association of Obstetricians and Gynecologists, and the American Academy of Pediatrics. The purpose of the intial and future conferences to be the solution of the common problems which have arisen and will continue to arise until a method based on American democratic principles shall be established and utilized.
>
> FURTHER BE IT RESOLVED, that copies of this resolution shall be sent to the Central offices of the above named and other interested organizations.

On Monday of this week, November 15, a meeting of representatives of the Academy of Pediatrics met with Dr. Martha Elliott of the Children's Bureau, in Cincinnati, and she expressed a willingness to follow the suggestion of the Academy's Resolution.

It has been recommended to the U. S. Children's Bureau that payment be made to doctors of medicine through Michigan Medical Service, our voluntary group Medical care plan. A poll of our membership has been taken and it indicates that such an arrangement is approved by great plurality. A special committee is handling negotiations with the Children's Bureau and Michigan Medical Service at the present time.

Pending the outcome of these negotiations and being cognizant of the many local problems confronting the profession throughout the state, the Executive Committee of our Council has registered the following opinion:

1. An unalterable disapproval of the plan in its present form.
2. That the members individually might properly
   (a) Sign the blanks to provide hospital service—giving the professional care gratis.
   (b) Sign the blanks and accept the government fee.
   (c) Decline to participate in the program.

(Continued on Page 12)

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caused by trichomonas vaginalis

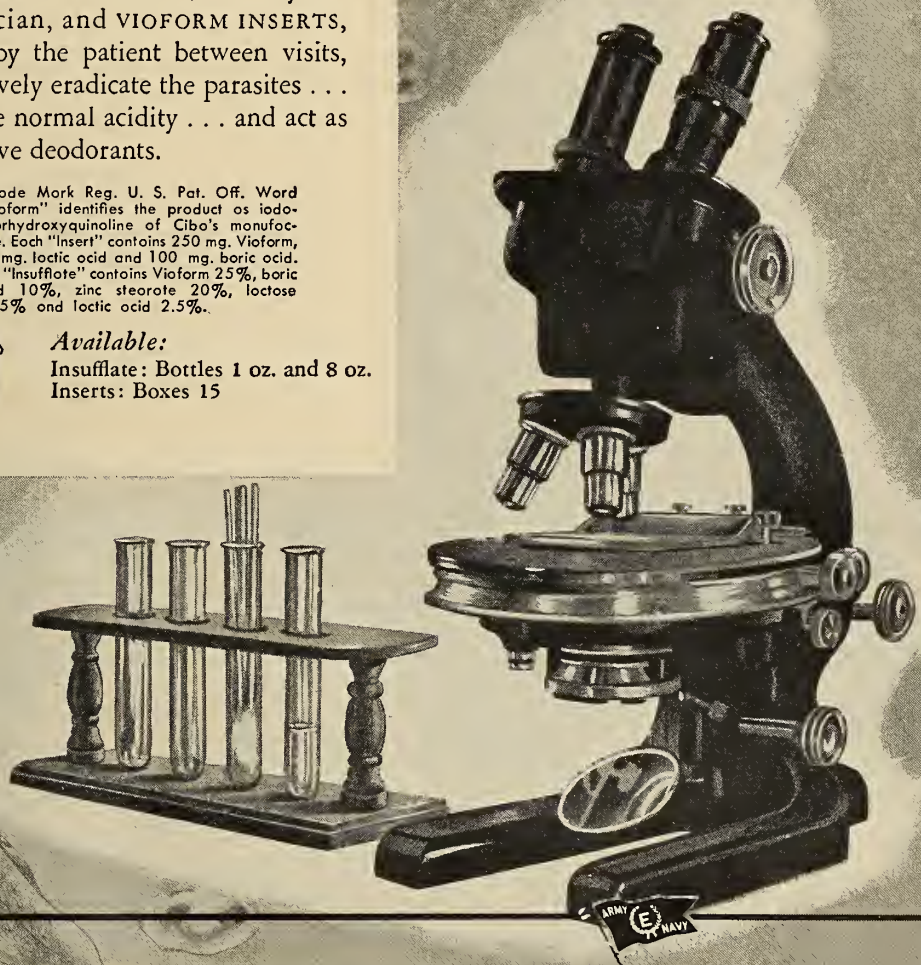
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WAR BULLETINS

(Continued from Page 10)

In conclusion we might summarize the whole subject as follows:

1. Everyone is desirous of having quality medical service accorded the dependents of our fighting men.
2. The program of the Children's Bureau is definitely one of Federalized or State Medicine with direct subsidization of physicians.
3. It does not insure quality service.
4. Federal health and medical projects are seldom discontinued after an emergency—this program is probably no exception.
5. The plan gives no assurance of a maintenance of reasonable fees (even if the present fees were considered reasonable).
6. The program is not limited to doctors of medicine.
7. The program could be used as a precedent to extend federal medical care to *all* branches of Medicine and Surgery.
8. Complete refusal to coöperate in the plan, even with an offer to render service gratis, might well evoke a criticism of the medical profession.
9. Official acceptance of the plan is a definite approval of Federalized Medicine.
10. Where participation in the plan seems necessary might it not be better to make such a participation on an individual basis—not on a basis of official approval by State Associations?

The Children's Bureau plan has been so developed, publicized, timed and administered that the Medical Profession is being forced to defend its traditions against a very vicious bureaucratic setup. Such defense calls for a concerted educational activity both with the public and with the Congress.

ACCELERATED INSTRUCTION SCHEDULE AT WAYNE UNIVERSITY

Beginning January 3 the Wayne University College of Medicine will go on an accelerated instruction schedule that will permit the graduation of fully trained doctors in three years instead of the present four. The speed-up will be accomplished by dropping the present semester plan in favor of a quarterly plan under which classes will continue throughout the year, instead of the usual nine months.

The quarterly plan will help materially in the present war emergency by cutting a full year from the usual time needed to obtain a doctor's degree in medicine. It will also permit further conservation of manpower, particularly in the instructional staff.

The new calendar year will be divided into four 13-week periods. Each period will be made up of eleven weeks of instruction, one week of examinations and one week of vacation. Successive terms will begin on the first days of January, April, July and October.

The quarterly plan will in effect allow one-third more work each year without increasing facilities. It will produce fully trained graduates in thirty-six instead of forty-eight months. This acceleration probably will be needed for at least five years after the war, in order to replace casualties, to take care of the needs of a substantial standing army, and to provide for expanding demands for medical services."

The quarterly plan ideally fits the wishes of the Army and Navy. The Services prefer a schedule of forty-eight weeks of instruction and four weeks' furlough each years. Of 204 students in Wayne Medical College, only five men and thirteen women are civilians. The remainder are in uniform—147 in the Army and thirty-nine in the Navy. They receive a private's pay, plus usual allowances and their books.

"Due to the accelerated medical course, 6,000 new doctors of medicine will be created every nine months of which 1,200 at most will enter civilian practice.

"There will be an annual loss of 2,000 civilian doctors of medicine whose places will not be filled with new graduates. This will be a serious problem after 1945."—James D. Paullin, M.D., President, American Medical Association.

* * *

"During the last two weeks, we discharged more medical officers than we inducted into the army."—Brigadier General George F. Lull at AMA Secretaries' Conference November 19, 1943.

* * *

"Thanks to first-rate medical care, soldiers of today will suffer no such epidemics of disease as those which in the primitive medicine of the Civil War killed fully 283,183 soldiers on both sides."—*News Week,* December 13, 1943.

A.C.S. WAR SESSION

The American College of Surgeons will hold a one-day War Session in Detroit at the Hotel Statler on Friday, March 10. The meetings will be open to the medical profession at large, including medical officers of the Army and Navy. The meetings will begin at 8:30 A.M. and continue throughout the day ending with dinner and an open forum with all participants in the day's program as the panel of experts to lead discussion of any and all subjects presented during the day.

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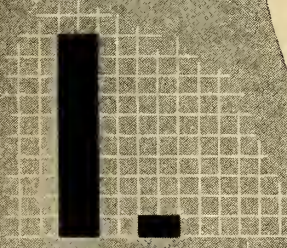
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RECENT OPINIONS OF MICHIGAN'S ATTORNEY GENERAL

1. A layman cannot fit artificial eyes, which is the "practice of medicine."

In your letter of October 25 you inquired as to whether a layman may use Butyn, a drug with anesthetic properties, in the fitting of artificial eyes and also as to whether a layman can legally fit artificial eyes. As to whether a layman may fit artificial eyes we are of the opinion that the fitting of artificial eyes comes within the term "practice of medicine" which is defined in part by Section 9 of Act 237, P.A. 1899, as amended, being the Medical Practice Act as:

"**the actual diagnosing, curing or relieving in any degree, or professing or attempting to diagnose, treat, cure or relieve any human disease, ailment, defect, or complaint, whether of physical or mental origin, by attendance or by advice, or by prescribing or furnishing any drug, medicine, appliance, manipulation or method, or by any therapeutic agent whatsoever."

While an artificial eye is not an appliance used to cure blindness it is nevertheless an appliance designed to form a protecting wall against the tissue and nerve ends surrounding the eye which when the eye is removed remain in a defective condition and the cure or relief of which would constitute the practice of medicine. For practical reasons, aside from legal reasons, the fitting of artificial eyes involves scientific consideration of the effect of pressure or the presence of a foreign body against sensitive tissue and nerve ends and also requires operations which might produce dangerous infection which might be transmitted to the afflicted person's other eye. We, therefore, conclude that a layman cannot fit artificial eyes and in so holding the question of the use of a layman of anesthetic drugs is disposed of.

A layman may, however, manufacture artificial eyes according to specification and prescription of a physician.

Yours very truly,

HERBERT J. RUSHTON
Attorney General

By

FOSS O. ELDRED
Deputy Attorney General

November 2, 1943

---

2. Physician may dispense small quantities of phenobarbital, chloral hydrate and paraldehyde without keeping a record of same where the physician personally attends the patient, and under other circumstances.

In your letter of October 6 you inquire as to whether, under Act 204, P.A. 1943, commonly known as the Dangerous Drug Act, a physician must keep a record of certain drugs described in that Act which he personally dispenses in his office or at the bedside of a patient.

Section 1. (b), of Act 204, P.A. 1943, reads as follows:

"Licensed physicians, dentists and veterinarians may dispense or prescribe barbituric acid and any of its derivatives, chloral hydrate or paraldehyde: Provided, That a record of all such dispensations, except administration to a patient upon whom such physician, dentist or veterinarian shall personally attend, shall be kept showing the date when issued and bearing the name and address of the patient for whom, or the owner of the animal for which the drug is dispensed, which record shall be open to inspection by any officer of any organized police force of this state or any prosecuting attorney or his investigators."

It is clear that the Legislature intended to require physicians to keep records of all such drugs sold at their offices as in the case of other vendors of such drugs. However, by including the exception above quoted no such record was to be required where the physician personally attends the patient at his office or at the bedside of a patient and hands the patient, or someone for him, a quantity of the drug with directions as to its use. If, however, a patient or someone on behalf of a patient calls at the physician's office and requests such drug and the physician does not consult the patient professionally a record must be kept of all such items containing such drugs as the physician or his nurse may dispense at that time.

The question at once arises as to whether a record must be kept where the patient or a representative calls upon the physician for another supply after having been previously so attended by the physician. To remove the physician from the category of a vendor only, it would be necessary for the physician personally to attend the patient each time the drug is given. Otherwise, the purpose of the Act would be defeated and the drug could be handed out to those for whom it was not originally intended. A common sense application of the foregoing would, of course, permit a physician to direct, at the time he attends the patient, that the patient or someone in his stead call at his office for further dosage, such additional dosage being a part of the quantity originally prescribed or advised This situation should not be confused with the case of a patient subsequently conceiving himself in need of the same medicine, requesting the physician to give him another supply.

On September 27, 1943, F. H. Taft, Director of Drugs and Drugstores, wrote a letter to Stanley W. Insley, Editor, Detroit Medical News, in which he outlined the provisions of this Act in relation to the dispensing of such drugs. His statement being concise and correct, I quote it with approval, and with his approval:

"First, this Act covers any items that contain any amount whatsoever of phenobarbital chloral hydrate and paraldehyde. Second, the doctors must write a new prescription each time. Third, he cannot telephone the

(Continued on Page 37)

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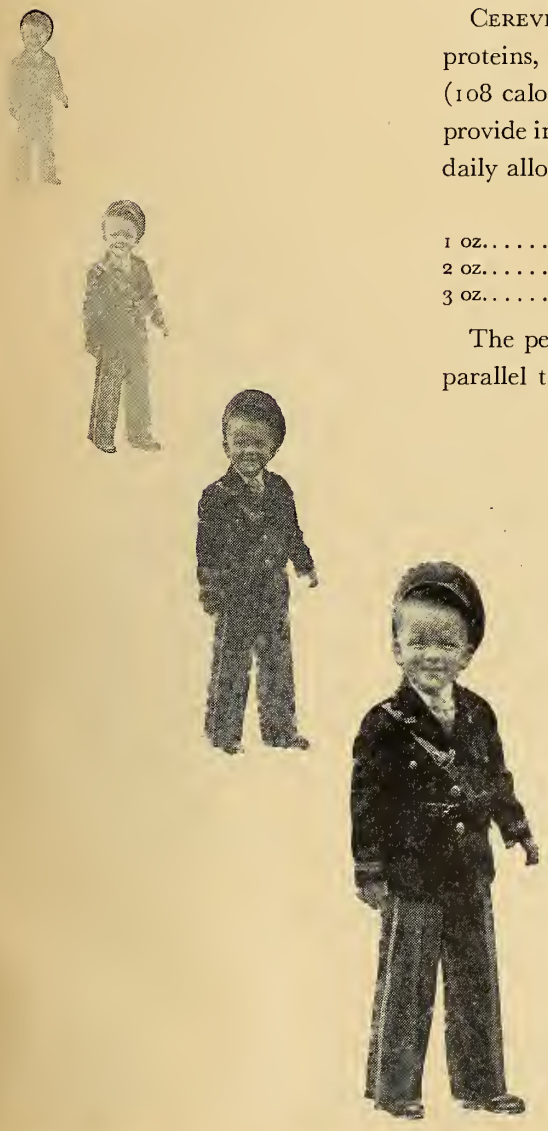
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"It is my hope that we shall never see medicine subsidized by the Government . . . I hope that the time never comes when the practice of medicine, or anything that has to do with it, has to come under government control. It would be a **disaster to this country;** it would be a disaster to medicine . . . "

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"A Disaster to This Country"

Do You Believe in Individual Rights for Americans?

The Wagner-Murray-Dingell Social Security Bills (S. 1161, H.R. 2861) —now pending in Congress, contain a medical and hospitalization section which would establish **a complete federal control** of medicine and hospital care in the hands of **one man,** the Surgeon General of the U. S. Public Health Service.

Your patients must learn from you, doctor, the facts about the present attempt to foist political medicine on them. It is the patient who will pay: First, in compulsory taxes!—Second, in a poorer grade of medical care which will result from federalized medical service.

Table of Contents

Certain Observations on Pains in the Head of Intranasal Origin.
Harold I. Lillie, M.D. 27

Treatment of Open Fractures.
Kellogg Speed, M.D. 33

Tularemia.
Edward F. Ducey, M.D. 38

Prognosis: Some Considerations.
Abel J. Baker, M.D. 39

Editorial:
The New Year 44
The Doctor and the Public 44
Have We a Program? 46

President's Page 45

You and Your Business 47

Communications 48

Michigan State Medical Society:
Seventy-eighth Annual Session—Proceedings of House of Delegates (Concluded) 49

Michigan's Department of Health 80

Woman's Auxiliary 82

County and Personal Activities 84

The Doctor's Library 89

War Bulletins:
The Federal Plan for Providing Obstetric and Pediatric Care for Wives and Infants of Servicemen.
L. Fernald Foster, M.D. 8
Accelerated Instruction Schedule at Wayne University 12

Recent Opinions of Michigan's Attorney General 14

Ask Your Patients 20

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Certain Observations on Pains in the Head of Intranasal Origin

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Headache should be looked upon as a symptom and not as a disease. The headaches caused by certain intranasal conditions will be discussed from the personal clinical experience of the speaker. Such headaches group themselves into rather definite patterns and should be readily recognized. Lantern slides of schematic drawings will, it is hoped, demonstrate the site and character of the conditions within the nose commonly encountered as causative factors in producing headache. Appropriate treatment is effective in relieving the distress.

■ Headache from whatever cause always should be considered a symptom and not a disease entity.

It is common experience for the rhinologist to encounter patients who complain of what they call headache. Invariably the patients think that they have "sinus disease." This diagnosis is arrived at from misinformation gleaned by transmission from person to person, from radio broadcasts advertising certain nostrums, from the misinterpretation of information presented in discussions by physician columnists in the lay press or most often, it seems, from the casual remarks of the general practitioner who has been consulted for relief of headache. It is incumbent on the rhinologist to recognize the patterns of pain in the head due to intranasal causes and it is still more important that he recognize headaches due to the many other causes. After all, the rhinologist is a physician primarily and a rhinologist secondarily. That relationship should not be lost sight of.

Actually, perhaps, it might be more accurate to designate the symptoms under discussion as "certain pains in the head due to intranasal causes" rather than include them under the broad term, headache. Really, headache is due to some disturbance of the intracranial pressure, whereas the pains under discussion are due to certain mechanical effects on nerve structures. It is not my intention to give a scholarly discussion of headache because that would take too long a time and serve no useful purpose. I propose to confine my remarks to the clinical aspects of my experience with patients complaining of pains in the head which were relieved by appropriate intranasal treatment.

It is difficult to define the term "headache" accurately. Actually at times the patient may not be certain of what he means by headache. When the patient can say that he has a "terrible headache right now" and still can smile and there is nothing to suggest from the countenance that any discomfort is present, it is hard to believe that any real pain or headache is present. The symptom may vary in degree from a sense of pressure to a well defined pain. When patients have headache the physician relies on the countenance and demeanor for suggestions of distress. In contradistinction to the sharp pain of neuralgia, or the continuous pain, tender-

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ness and redness usually accompanying neuritis, headache is a continuous subjective pain without external manifestations. The headache may be very severe or mild. Individuals differ in their reactions to pain and it is important in estimating the severity of pain to classify the patient as to his reaction to pain. It is obvious that if the patient is not given to exaggeration the complaint must be accepted with less reservation than if the patient complains bitterly of the slightest discomfort. Headache resulting from causes other than the intranasal structures will not be discussed except for mention in the differential diagnosis.

The clinical approach to the patient suffering from headache or pain in the head is important. The following information obtained from the history is valuable in suspecting the cause of pain or headache: How long has the pain been present? Usually persons, unless very susceptible to the effects of pain, are not disturbed by the occurrence of a pain which is not particularly distressing. In the past they perhaps have experienced the same symptom, to have it become relieved spontaneously. Therefore, if the pain has persisted over a week's time the probabilities are they will seek relief.

Then, it is important to know whether the onset was gradual or sudden and whether it followed an injury, persisted after an infection or occurred after a considerable lapse of time following an intranasal operation. If it occurred following an injury and to all appearances the patient has completely recovered from the injury, there must be some reason for the persistence of the pain. If it is not the result of injury, particularly if it has followed an infection, one naturally will suspect some involvement of the paranasal sinuses. If rather long delayed following the infection it may be due to intranasal adhesions. These adhesions might not be readily seen unless looked for specifically. If the pain followed long after an intranasal operation, again adhesions within the nasal cavity may be the cause of it. If the pain has gradually increased in severity, then one might suspect that, if it is not due to infection, it is due to the gradual aggravation of a mechanical cause.

Then one should know under what conditions the pain is likely to occur and whether it occurs daily or not. If the pain occurs under unfavorable weather conditions such as excessive cold or in high humidity or the environment of so-called bad air in crowded quarters, or fatigue, then one can suspect that it is due to swelling of the nasal membranes. If the pain is intensified under these conditions when the patient lies on the affected side, the fact would increase the suspicion that it was due to a mechanical cause within the nose, particularly if also the history is obtained that whenever the nose felt congested the pain was increased.

The time of day the pain occurs is important and it is more particularly important if the pain occurs each day. If the pain occurs daily during the morning hours and is not present at night, then one quite naturally suspects that an involvement of the paranasal sinuses is causing it, whereas if the pain occurs at irregular intervals as the result only of environmental conditions, one does not suspect the paranasal sinuses of being its cause. If the pain is accompanied by other symptoms such as nausea and vomiting and does not occur daily, one quickly thinks of causes other than the nose as an explanation for the pain or headache. Indefinite generalized pains or headaches are seldom if ever due to intranasal causes, so that if the patient complains of a sensation of a band constricting his head or in a definite localized spot feeling like a knife sticking into the brain, it is at once felt that the pain does not have any intranasal causative factor.

At times certain pains seem to be relieved by the relief of the nasal congestion. There may not necessarily be a purulent discharge but the patient usually complains of a thick, mucous discharge. That too is important because it means that whatever caused the congestion of the nose and produced the pressure on the nerve structures has run its course and the nose has begun to secrete and relieve the congestion.

Finally, it is important to know what the patients have found that relieves the pain. The common remedies, of course, are acetylsalicylic acid (aspirin, empirin or anacin), and bromoseltzer. Particularly in the instances under discussion it is important to know what effect intranasal treatment has on the pain. If the pain is relieved by the use of astringents or local anesthetic agents within the nose, that is important information. Headaches due to other causes are not relieved by the use of these remedies. Then,

too, it is important to know the effect of heat and cold upon the affected part. Heat is very likely to relieve the congestion within the nose and therefore relieve the pain. Cold in other

In acute infections of the upper part of the respiratory tract severe and distressing pain may be present. Relief for such a pain in the early stages of the infection may require large doses

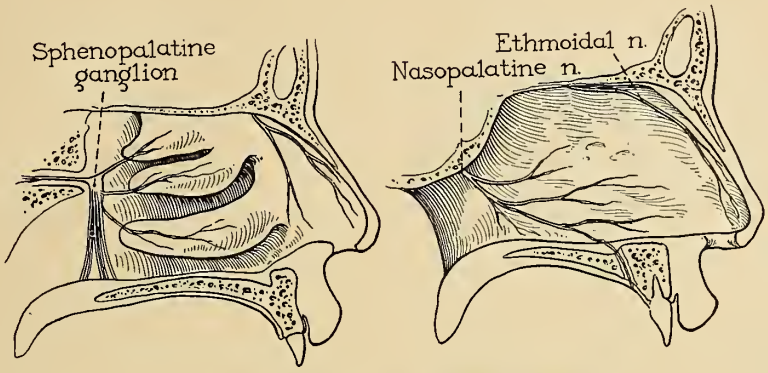


Fig. 1. Nerve supply of the intranasal structures.

individuals may have the same effect.

Nerve Supply in Intranasal Structures

The sensory nerve supply of the intranasal structures (Fig. 1) comes from the first division of the fifth nerve through the ciliary or anterior and posterior ethmoid nerves, which supply the anterosuperior intranasal structures, and the nasal or sphenopalatine ganglion, which supplies the posterior and lateral nasal structures and the nasal septum. The dura is supplied by a meningeal branch from the second division of the fifth nerve before it leaves the skull and a recurrent branch from the third division of the fifth nerve entering the skull through the foramen spinosum where it communicates with Arnold's nerve, a recurrent branch of the vagus nerve.

General Considerations

If the intranasal structures are normal in their anatomic relationship and are able to carry on their function in a normal manner there should be no cause for pain (Fig. 2). If an inflammatory process changes this relationship a cause for pain could exist. If as the result of injuries abnormal anatomic relationships exist or actual pathologic changes of the intranasal structures take place, sufficient reasons for pains would be present. Why certain individuals who have gross intranasal anatomic abnormalities or extensive pathologic processes do not have pain as an outstanding symptom may or may not be difficult to explain.

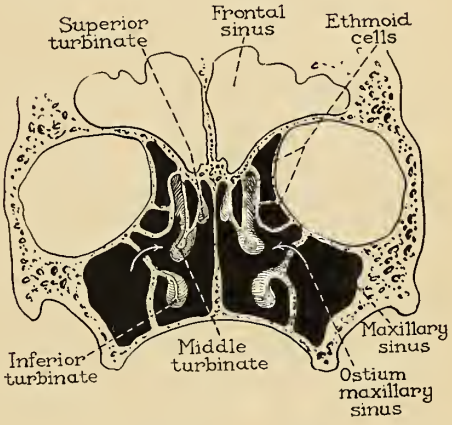


Fig. 2. Diagram showing intranasal structures.

of sedatives. There is prevalent the erroneous idea that the presence of such a pain means that pus under pressure is present. Nothing could be further from the truth. The pain is due to the intense swelling of the membranes in the confined spaces of the nose. When pus forms and begins to discharge, relief of the pain is afforded. Many serious complications have resulted from the effort to relieve such a pain by the puncture and irrigation of the sinuses in the stage of intense swelling of the membranes.

Headache or severe pain in the head occasionally occurs in chronic types of sinusitis if drainage or ventilation of the sinuses is interfered with. The pain may vary in intensity but is usually well localized and more or less constant. Such a pain occurs in mucoceles and pyoceles

of the frontal and ethmoid sinuses and in obliterative osteitis and tumors. Osteomyelitis always must be considered as a possible cause but usually there is other evidence. Should neoplasms of a size sufficient to produce pressure be

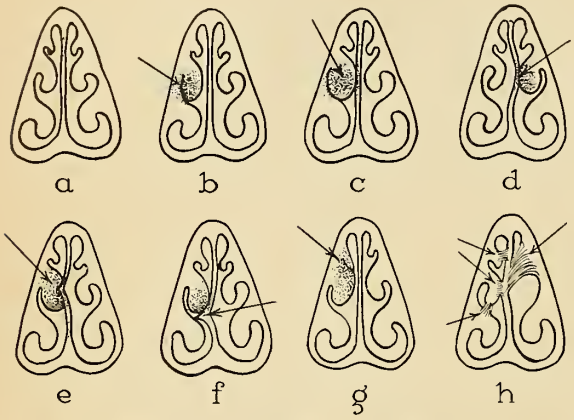


Fig. 3. Normal and various abnormal relations of the intranasal structures. For further explanation see text.

present, or should the neoplasm directly involve a nerve, pain may be the most important symptom. Pain produced by neoplasms too is more or less constant and increases in intensity as time goes on. It is well localized, usually to the region involved. Roentgenologic findings are very important in this group of patients but are not always diagnostic.

As intimated previously, pain may be a distressing symptom in acute sinusitis. The pain may originate from any or all of the sinuses. In the very acute stages it might be difficult to determine the sinus or sinuses causing the pain. The pain persists throughout the day and night. As resolution takes place the origin of the pain may often be determined but not by the location of the pain. Pain in the forehead may be due to involvement of the maxillary sinus and the frontal sinuses may not be involved. In subacute sinusitis pain is usually absent during the night. It makes its appearance after the patient arises, increases in intensity for several hours and then disappears around 1:00 or 2:00 p.m. Even if no treatment is instituted the pain gradually decreases in intensity, particularly if the drainage from the sinus is adequate. Any method of treatment designed to rid the sinus of the accumulated discharge relieves the pain.

The foregoing discussion was interjected merely to act as a background for the discussion to ensue. The pathologic causes for the pains now to be discussed are quite different.

My attention was first attracted quite accidentally in 1914 to pains in the head due to causes other than sinusitis. I had performed a septum operation for the relief of nasal obstruction on a patient who returned for observation after several months complaining of pain over the malar bone. The pain was more or less constant but increased in severity when he was exposed to cold air or when he lay on the affected side. There was no abnormal nasal discharge present. Examination of the nose revealed a band of adhesions between the septum and the middle turbinate bone. This adhesion did not interfere with breathing. However, when the adhesion was touched the pain in the malar region was intensified. Cocainization of the adhesion relieved the pain and then the adhesion could be touched without causing an intensification of the pain. Cutting the adhesion with a biting forceps relieved the pain.

Soon after this experience discussions appeared in the medical press regarding vacuum sinus pains and the Sluder sphenopalatine ganglion pain syndromes.

For convenience I have devised the schematic drawing shown in figure 3 to show several of the causes for pain about the head and face which occur as the result of certain anatomic abnormalities or pathologic changes. In this group there is no evidence of infection being present to act as the cause of pain. The history of the onset and the character, duration and relief of the pain are similar in most instances. Earlier it was intimated that certain questions reveal certain information that is important in suspecting intranasal causes for pains in the head of intranasal origin.

I might properly outline a hypothetical instance based upon experience with these patients. A male patient, thirty-six years of age, who had been exposed to all kinds of weather over a long period, complained that for the last six months or more he had had pain or headache, which had gradually increased in severity, and which occurred over the left eye, over the left malar region and behind the eye. He had noticed that it was particularly severe in cold weather and that

during warm weather he was largely relieved. He had thought little of it because at first the pain was not very severe. However, the pain had been increasing in intensity and caused him to take acetylsalicylic acid or some such remedy for its relief. Many times this afforded complete relief. He may have noticed that while a barber was using hot compresses over the face the headache would disappear. He noticed also that, when he had been working indoors for a number of hours and then was compelled to go out in the severe cold and windy weather, the change was sure to bring on the pain in the head. For these reasons he tried to avoid these exposures. No other symptoms, such as nausea and vomiting, were associated with this pain. It did not occur at any particular time of day. It did not usually occur daily unless the circumstances under which the pain came on were encountered. He had consulted a rhinologist who had shrunk the nose on occasions and relief was afforded for some hours following the treatment. The pain, however, would occur when the same environmental circumstances were encountered. With this information obtained from the history the rhinologist can suspect that the cause of the pain can be found within the nose.

Perhaps the most common intranasal causes for such pain are represented schematically in Figures 3*a, b, c, d, f, g,* and *h.* As one looks at Figure 3*a* one sees the normal relations of the intranasal structures and sees that the structures lie free and do not contact one another in any way. Seldom if ever do the intranasal structures exist in this relationship, though for purposes of demonstration Figure 3*a* serves a useful purpose. The most usual cause of pain of this character is a contact between the anterior end of the middle turbinate bone and the septum (Fig. 3*d, e,* and *f*). There is usually a bulge or deflection of the septum toward the turbinate or the turbinate may have become large and cystic and consistently press the two surfaces together. Any physiologic response of the nasal membranes which causes them to swell intensifies this contact and increases the severity of the pain. The pain may be situated over the malar bone but it is most usually situated over the root of the nose or over the frontal sinus. Cocainization of the anterior ethmoidal nerve may relieve the pain completely. If cocainization relieves the pain the diagnosis of the cause of the pain is determined. Relief from the pain is afforded either by doing a septum operation and removing the anterior end of the middle turbinate bone or by crushing the middle turbinate and pressing it into a more normal relationship with the lateral nasal wall and the septum, thus avoiding the contact. Occasionally if the middle turbinate contains ethmoid cells which increase in size, it becomes what is called a cystic middle turbinate and the same symptoms may be produced if contacts are present even though the nasal septum is straight (Fig. 3*c*).

Because of our present knowledge of the function of the nasal structures the day has passed when operations designed to remove or destroy the functioning mucous membrane are looked upon with favor. The tendency among rhinologists, and fortunately so for the patient's well being, is to conserve the mucous membrane if possible. If a cystic middle turbinate is found to be the cause of the pain the lateral nasal half of the turbinate can be removed and the septal half may then be placed back into the middle meatus region, thus conserving the septal surface side of the turbinate for function. This is preferable to removing the septal side because there is less danger of adhesions forming between the middle turbinate and the septum. Then when the air stream enters the nose, functioning membrane is encountered instead of scar tissue.

Reference to Figure 3*b* shows schematically a middle turbinate which is impacted against the lateral nasal wall. The same symptoms may result from this abnormality as from contact between the middle turbinate and the septum. If the turbinate is not too large it can be infracted away from the lateral wall and relief of the pain is effected. Crushing the turbinate may be effective because it allows a large middle turbinate to assume more normal anatomic relationship with other structures and this prevents the normal physiologic swelling of the nasal membrane from causing contact. Only occasionally is partial resection of the turbinate necessary to afford relief. This is the type of condition which I think was formerly associated with the so-called vacuum type of headache. I once had a patient who presented this condition and when the region of the middle meatus was thoroughly co-

cainized and shrunken he said he felt air go into the frontal sinus and immediate relief of the pain was afforded. It is possible that the swelling of the membrane would close the nasofrontal duct but I am not at all certain that any vacuum was present in the frontal sinus. What is more likely is that the cocainization anesthetized the nerves and reduced the swelling and in that way produced relief.

Another common cause for the type of pain under discussion is a wide septal spur and deflection (Fig. 3*e* and *f*) contacting the superior surface of the inferior turbinate, impinging tightly into the middle meatus or contacting the septal surface of the middle turbinate. Patients suffering from this condition have been observed in whom it was not possible to reduce the contact or stop the pain completely by cocainization because the bone of the septal spur and the bone of the lateral nasal wall were in such tight contact. However, correction of the anatomic abnormality by a septum operation did relieve the pain. Williams has been observing a group of patients who had what he chooses to call a vasodilating pain syndrome in which such a bony contact has acted as a trigger. Relief from the pain could not be accomplished by the use of nicotinic acid until the contact within the nose was removed. Recently I had a patient who had such a tight contact that the pain was not relieved following the septum operation until nicotinic acid was used in the postoperative convalescence for its effect on vasodilatation. More must be known about the physiology of vasomotor control before this pain syndrome and the relief afforded by treatment with nicotinic acid can be explained in a satisfactory manner.

A very uncommon cause for pain has been encountered in six cases (Fig. 3*g*). It is a contact between the superior turbinate and the upper surface of the middle turbinate. This anatomic relationship might not readily be discernable even after thorough shrinkage and cocainization of the nose. From inspection one might expect that the pain was due to an impaction of a large middle turbinate against the septum or the lateral nasal wall, but when the impaction had been relieved the pain was not relieved. Even more thorough cocainization of the region may not relieve the pain. An examination with a probe on the upper surface of the middle turbinate may quickly find a trigger zone which intensifies the pain and further examination may disclose that the probe fits into a sulcus between the turbinates. Then if the middle turbinate is infracted away it is readily seen that a contact between the middle and superior turbinates has existed. This procedure occasions complete relief of the pain. In the six cases that have been observed the relief was dramatic. In one it was necessary to remove the middle turbinate and to press the large superior turbinate, which was much larger than would be expected to be normal, back into the position that the middle turbinate had occupied. Function of the nose was not disturbed in any way and the patient was completely relieved of the pain.

It is fairly common for patients who have had otherwise satisfactory intranasal operations for the relief of nasal obstruction or of sinusitis to complain that they did not have any symptoms of pain referable to the nose until several months after the operation; then increasing gradually in intensity a pain became annoying and finally distressing. It is usually localized well to the root of the nose, the malar region or the forehead. Because of the experience in many of these cases when such a history is obtained, I purposely look for adhesions. They may be present between the middle turbinate and the septum (Fig. 3*h*) either anteriorly or posteriorly, sometimes over a wide area, or there may be simple bands of adhesions looking like stretched rubber bands. Such adhesions may escape notice unless looked for. They also may be present between the middle turbinate and the lateral nasal wall and the middle meatus. At no time have I encountered an adhesion between the septum and the inferior turbinate that caused pain. Sometimes it is difficult, if the space is narrow, to avoid reformation of the bands of adhesions.

On several occasions a patient has given a history that, after a severe infection of the nose, pain has persisted and the examination did not reveal any evidence of infection, but close examination reveals the presence of adhesions. It is highly probable that in certain severe nasal infections an ulcerative process takes place and adhesions form after resolution of the infection has been complete.

Summary

Several causes for pains in the head due to certain intranasal conditions other than infection of the sinuses have been presented.

Methods of diagnosis and differential diagnosis have been discussed.

The treatment for the lesions readily suggests itself when the causes are determined.

Care must be taken that subsequent postoperative adhesions do not defeat the purpose of otherwise well directed treatment.

No attempt has been made to give a scientific or scholarly discussion of headache.

The clinical experiences that I have had are presented for what they may be worth to other observers.

MSMS

Treatment of Open Fractures

By Kellogg Speed, M.D.

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Defining open fracture as one communicating with the air from whatever cause or route the treatment is outlined as follows: The patient himself, the conditions under which he is found, his state of shock as from hemorrhage, the various methods of combating blood loss; the condition of the wound at the time of first aid, means and methods of splinting and fixation and preparation for transportation.

When definite treatment is possible in hospital or suitable surroundings an assay of the wound and fracture before débridement is required, the period of contamination is mentioned and the operation described. Internal fixation and types of splinting and their use, are outlined, including the Stader splint. The use and dangers of sulfa drugs and antitetanic serum are covered and other antiseptics are mentioned.

■ If physicians will admit to themselves that an open fracture is one which communicates with the air by any route and has resulted not only from external violence applied to the part, but in some instances also by bursting out of the bone through the soft parts even through a small opening, the treatment demanded will assume a serious, time-taking, yet worth-while care. Some bones may have a natural tendency to ward off grave consequences of open fracture and exposure to infection. The jaws, the facial bones and even the skull appear less liable to spreading or fulminating infection with serious consequences. I speak only for the skull itself, not its contents. Most long bones with definite medullary cavities, with adjacent joints at their extremities opened to the air by fracture, may become infected by contact with external soiled surfaces, penetration or seepage and, being unprepared by natural surroundings and anatomical plan for such infection, often succumb to an easy transmission of the virus. These bones are as prone to spreading infection as aboriginal races are to our common exanthematous diseases. Let us therefore treat any open fracture with respect, with unhurried and not with amateurish effort which may result in a prolonged osseous or joint infection and sequences which may continue for years.

Open operation on closed fracture, bringing the fracture into an open wound may likewise lead to disaster when performed even under ideal surroundings. The most careful operative asepsis in a hospital operating room results in from two to five per cent of postoperative infections with their unhappy sequelæ. Therefore let us beware the casual daubing on of an antiseptic solution over an open fracture or over-reliance in the miracle of sulfa drug action placed in the open wound either in crystalline or emulsion form. Let us return to sound, tried surgical principles and not be shunted away from the well-known facts of bacteriology, physiology and pathology. The best surgical efforts and researches of two world wars have failed to give us 100 per cent healing of open fractures without infection. Although by clinging to the surgical principles required, by shortening the time interval factor before surgical treatment and the use of modern bacteriostatic drugs, the mortality and rates of infections have been lowered. The treatment of open fractures in civilian and industrial life is just as important to the nation's welfare and maintenance of man power and national economy as that given wounded men in the active services. We on the home front must consequently subject ourselves to as rigid a self-dis-

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cipline of thought and action in the care of these injuries as if we had to make an immediate report to a commanding officer and a long continued, searching follow-up to determine results. Such results include expense to employer and injured, disability, loss of working hours, and too frequently final mutilating operations for amputation or joint resections. An open fracture of a phalanx must come under the same rules for care as the shaft of a femur—who shall say which may become the most important? To quote from a recent article by Baker:

"In a compound fracture there are four challenging factors: foreign material, devitalized tissue, the disturbance of the anatomical relationship of the parts, and infection. When properly used, the sulfonamides may help in ridding the wound of only one of these, infection. If the first three factors are not remedied by the surgeon, catastrophe . . . is frequently the result."

The following points in sequence should cover the treatment of open fracture:

1. *First-Aid Care.*—This means attention to the patient, his protection against further injury such as burns, exposure, run over accident, crushing from collapsed structures, or gun shot fire. Most first aid is given by laymen, but the physician should be able to train laymen for this work. In case of added hazard after fracture, the injured may be dragged away on a blanket or coat, as gently as possible to a safe position but usually first aid should be given on the site of accident. The control of pain and an effort to stop additional blood loss and increasing shock are the prime purposes.

Morphia and the transfusion of blood plasma, glucose or salt solution by means of the compact field kits which every physician or ambulance should carry assure the partial replacement of fluid volume in the circulatory system under the most trying circumstances. For a clinical estimation of blood loss and shock, in addition to the condition of the pulse, pallor and respiration, one may rapidly weigh such factors as the bone involved, age of the patient, single or multiple fractures, degree of comminution, severity and type of the causative trauma, proximity to large joint or cavity, as the abdominal cavity in fractures of the pelvis, into which a large amount of blood may burrow or seep, and finally the muscular development which may be responsible for local blood loss.

Many of the factors causing shock may be favorably influenced by early and gently applied fixed traction, protection against chilling both beneath and around the injured, and application of moderate heat, not enough to cause sweating and additional loss of body fluids.

2. *Treatment of wound.*—Attention to the wound accompanies Point 1 and follows at once. If active hemorrhage is present local pressure by a clean dressing if possible may and usually does control it. Only sufficient opening of clothing is made to view the wound—no attempt should be made to remove all clothing unless contaminated with harmful chemicals. A tourniquet is rarely required. It is dangerous and if found on a limb should be inquired into at once. Loosening and reapplication if needed every twenty minutes during transportation for treatment is imperative. Sulfa drugs if available may be spread over and into a wound in known quantities, seldom exceeding five grammes, depending on the size of the wound. Eventually emulsions of these drugs may be used out of sterile containers like tooth paste tubes. If bone projects from a wound, which may cause awkwardness in handling the limb, prolong hemorrhage and invite infection, it is my firm belief that the limb should be placed in a position of normal axis replacement even if this bone is drawn back into the soft tissues and disappears. The normal axis of the limb kills dead space around the fracture in part, lessens hemorrhage and permits easier splint application for transportation.

3. *Splinting and Fixation of the Part.*—If the physician or an ambulance has arrived there should be in the automobile Thomas leg and arm splints to apply. If they are wanting, a leg may be tied to its fellow after gentle traction to straighten it out and any means of splinting at hand employed. An arm can be gently supported on the torso using any kind of padding from a sock to a hat—the main injunction being the utmost gentleness in all handling of the parts.

4. *Transportation to a Place for Proper Care.*—The place for proper care is generally a hospital or place of refuge. Transfusion may con-

tinue during transportation. A flat surface, a stretcher or litter and not the narrow seat of an automobile is the best. Recall Percival Potts sustaining an open fracture on the street in London —who lay for some time on the wet pavement while he persuaded someone in the gathering crowd to go purchase a door for him on which he was eventually carried to Guy's Hospital without additional trauma. That was a smart act—we should be equally smart after these more than a hundred intervening years. Gentle traction applied about wrist or ankle without attempt at removing shoe affords fixed traction for transportation, a most valuable guard against pain, shock, additional blood loss and spreading infection.

5. *Examination.*—Arrived at a place for corrective treatment an assay of the patient's condition and of his wound must be made again—before x-ray examination, if available, need be considered. If the control of hemorrhage and shock is well in hand there is no objection to x-ray examination through splints and clothing in passing through the hospital corridors to an operating room. Exceptions may be found in spine and skull injuries. This assay will determine the magnitude of the surgical effort required to meet the specific case so that preparation of splints, instruments, additional blood or plasma transfusion, if shock is uncontrolled, or consent to amputation or surgical procedure may be obtained. It is best to combat shock with heat and intravenous fluids and delay operation rather than to rush into a surgical job and have the patient succumb on the operating table or soon after removal from it. Some conditions require a nicety of judgment not obtained solely by a blood pressure apparatus or any examination based on mechanical means.

6. *Contamination.*—An estimation of the local contamination involved in the open fracture is independent of the size of the wound but may depend on the part of the body involved, the locale of the injury, whether a barnyard, fertilized earth or a machine shop and the individual's natural cleanliness. The types of bacteria to be fought may thus be anticipated. The standard of the operative treatment will however remain reasonably uninfluenced and must be thorough in any case.

7. *Time Element.*—The time interval after injury and final reception of the patient for definitive care is important and is weighed in the light of Point 6 more than in an estimation of the size of the wound and the bone involved. In theory a time interval of four hours or less is most satisfactory in the hope of obtaining a clean wound and good healing by surgical effort. In reality depending on some of the factors covered up to this point, eight hours may not be too long a period. With the help of bacteriostatic drugs this period may be increased—but not surely and safely more than twelve hours before debridement. Expedition in first aid and in transportation of the injured individual thus assumes great importance. In modern factory and even in mine injuries these points have been given consideration and resulted in great reduction of percentage of infections and unhappy results.

8. *Debridement.*—Debridement under the best conditions possible as in an operating room, then follows. This aims to change by mechanical dissection and removal of contaminated or dead tissue, a potentially or really infected wound into a clean wound. It involves gentle and thorough local cleansing of the part sometimes preceded by the introduction of skeletal traction in the limb or area. Soap and water gentle scrubbing, in some instances aided by other solvents to remove thick grease or contamination and sterile draping of the area, are required. The operation is not hurried, is aided by extended incisions in the proper axis of the part and gives full view of the wound of soft parts and bone. All contaminated, tousled and potentially necrotic tissue is removed in an effort to get a mechanically and incidentally bacteriologic, clean wound. Each layer is dissected gently in turn. Retraction and light must be sufficient and many such wounds are treated after application of a constrictor on the limb to prevent flooding with blood to aid in a more rapid dissection. The constrictor, however, has its faults as after its removal the paralysis of vaso-constrictor nerves may be such that the subsequent hyperemia leads to further blood loss or the temporary ischemia may extend tissue necrosis. No hard and fast rule can be applied —each case must be judged separately. Bone may be cleansed as any other tissue—soiled surfaces may be rongeured away and no sizable frag-

ments are taken out, certainly none with periosteal attachment and blood supply. The wound however must be thoroughly cleansed and may be irrigated with large quantities of normal salt solution to wash out clots and unseen small loose fragments of tissue—a minimum amount of bleeding point ligation is advisable even after removal of the constrictor, if used.

The type of anesthetic employed will depend on the operator's choice, the patient's condition and the extent of the wound—but in my opinion local anesthesia is not to be employed. It certainly has an inhibitory effect on sulfa drug action and has no place in this type of surgery for children.

9. *Splinting.*—Attention to the alignment and bone reduction enters at this point. It may be obtained by simple kissing apposition of a transverse fracture. It may require the use of internal splints such as plates, screws, bands or nails. It may demand accessory skeletal traction on the line as a whole, to be further secured by plaster of Paris encasement or skeletal traction with external fixation by bars or supports outside of the limb or surface of the part. This practice is old—was long ago abandoned and has been revived in recent years by Roger Anderson and others—the Stader splint, obtaining this idea from Anderson, uses adjustable metal bars fastened to pins set in the bone fragments—usually at a distance from the wound site.

The insertion of these pins calls for an accurate anatomical knowledge, an excellent x-ray control and a certain mechanical dexterity not achieved by all. It has certain dangers as of introducing infection, of splitting long bones and of loosening at inopportune times. It is hardly a method for universal use, or for the casual operator and requires daily follow-up care. The United States Army frowns upon this method, the Navy adopts it for many of its fractures and time will eventually shelve it in its proper niche. Any method of internal fixation will not shorten the natural period of bony union—but it may make it a little more certain in many instances. It has complications and under properly-controlled care the patients may become ambulatory —but still should be guarded against weight bearing or unwise muscle strain until natural bony union, independent of the mechanical assistance of the fixation agent has followed. This has been definitely proven in the internal fixation of fractures of the neck of the femur for instance. The so-called Trueta and Orr treatment of open fracture must depend on the old principles of debridement, a relatively clean wound and fixation by plaster or other type of external splint. We must stick then to these points: obtain a clean wound, whether packed open or closed, a complete bone realignment and lastly, fixation by any means until the bone heals, till supporting trabeculæ reform and the part will be able to resume its normal functional use without secondary deformities, delayed union, or other unhappy result.

10. *Sulfonamides.*—The use of sulfa drugs is such a large subject that only a few points can be mentioned. I believe that they have a definite place in first aid and in follow-up treatment used in the wound at the time of debridement and subsequently at the infrequent dressings required by the open fracture and also parenterally during the period of possible infection in the wound, up to three weeks. Here in Detroit, at the Ford Hospital, Mitchell reports a definite drop of infection after open fracture from 20 per cent to 9.7 per cent or better, using these drugs. New practical points in their use seem to indicate a maximal local dosage of 8 grammes in large wounds—and the use of sterile gauze packing. In children the dosage may be confined to 0.1 gram per kilo of body weight. When given by mouth the optimum blood plasma level is probably between 5 and 7 mg. per cent. New means of detoxication of the sulfa drugs include the simultaneous use of calcium glucuronate or a combination of amino acetic acid, cystine, calcium glucuronate and ascorbic acid by mouth. In debridement and wound dressing all inhibitor substances must be avoided. From a practical standpoint this includes novocaine and all proteid products as from blood clot, etc.

The sulfa drugs, however marvelous their action may be, cannot overcome the depressed condition of the unfed, cold, dehydrated, overfatigued and overexposed patient with the open fracture.

We await the more general use of penicillin and the reports of its action. It may be even more

potent and less harmful than sulfa drugs for some infections.

The paste of Rutherford Morrison, B.I.P.P. is still used by Canadian surgeons as a film application on thoroughly dried debrided wounds of open fracture. I have used it many times and believe it has decided merits when properly employed.

Potentiated sufonomides are now being used. Oxidizing agents such as zinc chloride, azochloramide and solutions of iodine and potassium permanganate are supposed to add to the bacteriostatic power of sulfa drugs. Medication alone will probably never cure the pyogenic infections and every thought must be given to the preceding paragraphs in employing any chemical gent.

11. *Antitetanic Serum.*—This is indicated for all patients with open fracture unless they have been immunized by tetanus toxoid. If they have been given the toxoid they may be given a 1 c.c. dose of antitoxin to raise their antitoxin titre still higher. To quote Firor:

"The toxic molecule produced by clostridium tetani is probably altered within the substance of the nervous system to form a secondary toxic body, which in turn is absorbed by the blood. This secondary substance is not neutralized by ordinary tetanus antitoxin."

Death in tetanus is probably due to such a secondary toxin circulating unneutralized in the blood. Respiratory depressants, especially the barbiturates, will hasten death in tetanus. For active treatment of tetanus we should give 50,000 units A.T.S. on diagnosis, to neutralize the free and unaltered toxin circulating in the body. We may then inject around the wound (if the exact wound is known as in open fracture) 10,000 units and an hour later excise the wound. This is followed by giving slowly, 15,000 to 20,000 units intrathecally. The use of oxygen, food, the Levine tube to ensure food taking and to avoid vomiting and even trachectomy go along with the necessary quiet and non-irritating darkness for treatment.

Summary

In the treatment of open fracture, postoperative and fixation care, by any method, is exacting. If possible, it is best given by the surgeon himself, observing for changes in circulation, evidences of gas infection, incipient gangrene and general complications of systemic nature.

A minimum of dressings and disturbance of wound, vaseline gauze packs performed while wearing sterile gloves and covered mouths and heads of all concerned and the patient's quiet and rest are advised.

The sulfa drugs may be used in open wounds when and if dressings are changed, with due regard to blood plasma levels and toxic symptoms from absorption. The use of sulfa drugs by mouth or intravenously has been touched upon; the attempt to control tetanus described.

The greatest support in the hands of the surgeons is borrowed from the obstetrician; patience and "watchful waiting."

Roentgenograms at properly spaced intervals, not too often, give information and encouragement.

No open fracture should be submitted to too early functional strain and use.

Local osteomyelitis, thrombosis, embolism and other unhappy complications must be dealth with by orthodox surgical measures.

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RECENT OPINIONS OF MICHIGAN'S ATTORNEY GENERAL

(Continued from Page 14)

prescription to the druggist. Neither can he use a telephone order to refill one of these prescriptions now on file. Fourth, should the doctor dispense any of these items it is necessary that he keep a record of each instance that he dispenses. This record must contain the following information: the name of the patient, the address of the patient, the date dispensed, the name of the doctor and the amount of the drug dispensed. Fifth, when dispensing the doctor must place a label on the package that he dispenses, which carries the name of the patient, the address of the patient, and the doctor must have his name on this label."

The case of Peter Young vs. United States, 62 Sup. Ct. Rep., 510, to which you refer has been considered and is in accord with this opinion.

I trust the foregoing will answer your inquiry and be helpful to the members of the medical profession.

Yours very truly,

Herbert J. Rushton,
Attorney General

By Foss O. Eldred,
Deputy Attorney General

Tularemia

A Case Report

By Edward F. Ducey, M.D.

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Cumulative evidence year after year indicates the extreme danger connected with handling of tularemia organisms. Another instance of clinical infection in a laboratory worker during routine bacteriological study is described; approximately fifty such cases have now been recorded. Other and less dangerous means of diagnosing tularemia are discussed.

■ Exposure to more or less virulent organisms is the daily experience of most medical technicians, and the relative infrequency of infection among them from accidental contamination in the laboratory bespeaks a sound training in, and faithful practice of, the many precautions which have been developed to reduce the incidence of these unfortunate accidents.

Pasteurella tularense is one of the most dangerous bacteria encountered in hospital practice, because of its ability to penetrate the intact skin; this faculty explains the frequent hand infections acquired by hunters in skinning or dressing diseased animals, as well as the one described here. In 1937 Francis[2] was able to locate accounts of thirty-seven cases, reported from thirteen laboratories throughout the world, occurring in workers handling infected material; undoubtedly this number has been considerably increased to date. So far as we have been able to discover, this is the first such accident in Michigan.

Case Report

S. B., a white woman, aged twenty-nine, and a laboratory technician at Mount Carmel Mercy Hospital, was admitted as a patient on October 18, 1941, complaining of acute malaise, chills, fever, chest pain, and a boil on one finger. Five days prior to admission she had inoculated a guinea pig with a forty-eight-hour culture of *P. tularense,* obtained from aspirated material from the regional lymph node of a proven case of tularemia. During the procedure, some of the material was spilled over the fingers of one hand; she immediately washed her hands thoroughly and forgot the incident. (There were no known cuts, excoriations, or other lesions on the fingers which might have provided a portal of entry.) Three days later a small red papule appeared on the left index finger, becoming pustular thirty-six hours later. The syndrome of acute infection set in rapidly thereafter, with some pleuritic pain in the left chest and associated left axillary adenitis.

Physical Examination revealed an acutely ill white woman whose temperature was 103.6° F., pulse 110, respiration 24. There was a friction rub at the left base. On the dorsum of the left index finger was a pustule 4 mm. in diameter, the base of which was very much indurated; the left axillary nodes were enlarged and tender. Laboratory findings were essentially normal except for a moderate leukocytosis and a doubtful intradermal skin test for tularemia. Because of the significant history, pus from the furuncle was examined immediately; direct smears were negative but a 48-hour culture showed many typical tularemic organisms. On the fifth day after admission, the patient's serum had an agglutination titer of 1:160 against tularemic antigen; two weeks later the titer had increased to 1:1260, and six weeks later to 1:3780. On the third day after admission the antigen skin test was strongly positive. Because of the prominent pulmonary symptoms and severe toxemia, the patient was given a total of 180,000 units of anti-tularemic serum over a period of five days. Pneumonia did not develop but a severe serum sickness lasting six days was a disturbing complication. The patient remained in bed a total of twelve weeks and was not completely well for another sixteen weeks.

Comment

The ability of *Pasteurella tularense* to produce a lesion in healthy skin indicates the danger to which bacteriologists are exposed in handling the organism, and prompts the opinion that routine cultural studies in frank or probable cases of tularemia should not be attempted; the usual ulceroglandular or oculoglandular complex, plus a rapidly increasing agglutination titer, are sufficiently diagnostic when considered in conjunction with a typical history and an acute febrile syndrome.[1] The reaction to antigen injected intradermally is usually positive by the end of the first week of the disease,[3] providing a reliable exclusion test, and still other confirmatory procedures are available if needed.

Summary

An instance of tularemia contracted by a hospital laboratorian during the performance of routine bacteriological study is described.

From the Clinical Laboratory, Mount Carmel Hospital, Detroit, Michigan.

Search for the causative organism in a tularemic patient is a dangerous procedure, and is not warranted in the usual case, in which diagnosis is readily accomplished by other means.

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Prognosis

Some Considerations

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Attention is called to some of the problems of prognosis and to the desirability of more serious consideration of the subject. Some of the desiderata for making a reasonable prognosis are discussed, along with the difficulties frequently encountered. Brief comments are made on the prognosis of some of the more common medical conditions. A plea is made for more thought on this important subject.

■ In the study of a patient a physician must consider three problems, namely—diagnosis, treatment and prognosis. Obviously diagnosis is the most important; prognosis most difficult, most neglected, and therefore merits more consideration. Long ago, Hippocrates said, "I hold that it is an excellent thing for the physician to practice forecasting."

An understanding of the natural causes of a disease must be the basis of a good prognosis. It involves an appreciation of the entire pathological picture a patient presents, and not merely a diagnosis of the condition for which he consults you. A troublesome cough or an abdominal pain may be serious or not. To be able to give a favorable prognosis gives comfort and assurance which plays a large part in treatment. In all illnesses, serious or not, the patient or family are anxious to know what the outcome will be, much more than they are in any precise diagnosis or scientific term for the ailment. They want a diagnosis, but chiefly to judge the prognosis. They want to know if the patient is going to recover.

Anxiety and emotional upsets often affect body functions and may be very harmful. A favorable prognosis is the best remedy. A change in the whole attitude of patient and family often follows. Except in very hopeless circumstances it is poor policy to give a bad prognosis. Attitudes of extreme pessimism and head-shaking are not justified as a rule. Except in inoperable cancer, moribund states and a few other progressive ailments, we never have absolute certainty of a fatal result. We all see patients recover from grave diseases, pneumonia, septicemia, heart failure, hemorrhage etc., which in our judgment at the moment are hopeless. Except in such conditions and in old age the chances of recovery are greater than otherwise. Children especially make remarkable recoveries. It is therefore wise to give a good prognosis in all cases in which the evidence justifies it, and when doubt exists to give the patient the benefit of the doubt. In cases where the Doctor himself is in doubt, it is still reasonable and kind and useful, to stress the favorable features in discussing the case with relatives or friends, and to congratulate the patient on his courage and coöperation and any gain he may have made. A bad prognosis may do great harm and cast a gloom over the entire family.

Guarded Prognosis

It is always possible to give a guarded prognosis. Optimism is rarely held against the Doctor, while pessimism is, even when it is justified. In many cases of "Guarded Prognosis" we perhaps do not delude ourselves and we may give more hope than the case justifies, but we should stress the favorable features. If, in our judgment, the prognosis is absolutely hopeless we must inform the family.

It sometimes is very important for a patient to know about how long he will be sick. In acute conditions, many of which are self-limited, we may give a fairly close estimate. In others we may be able to give a rough guess, but often this is appreciated. Time and nature frequently give us great assistance. However we must keep in mind always the possibility of complications which may completely upset our prophecy. This is true of any case, acute or chronic.

Prognosis also requires some acquaintance with mortality and morbidity statistics, death rates at certain ages, knowledge of human constitutional factors which affect morbidity, the good or bad effect of treatment and the patients response to it. All of these together with a good working knowledge of anatomy, pathology and psychology, will add to one's ability to make a good prognosis. Experience in these fields along with good clinical observation, a good memory and a desire to know what happens to patients after they leave you, will make for a better prognostitian.

Great difficulty sometimes arises when the question of whether or not to operate confronts us. Is the operative risk greater or less than the disease if left to nature or medical treatment? Operation is the treatment of choice in many conditions, but complications may make it desirable to delay surgery. Will the patient's prognosis be improved is the question. In such a case it is always helpful and comforting to consult a colleague in whose judgment you have confidence and go over all the evidence and the probabilities before making a decision. After all a patient half cured is better than one entirely dead.

Favorable Prognosis

In giving a favorable prognosis a doctor must believe that it is possible to help the patient to such an extent that he may improve or get well. We should not always assume a doubtful attitude. Assuredly we cannot always talk with the degree of confidence we would like to have, but it gives a bad impression when we seem to distrust all therapeutic agents. This is probably the reason why many neurotics are helped by quacks of all sorts. The quack never doubts that he can cure a case and he never lets the patient forget it. His "cure" may be of short duration but if he had no success he would have no patients and we all know he has them, often in abundance. We cannot always predict cures but we can at least claim with good conscience that we can help the sufferer.

Opinion as to the health and duration of life of a normal person is the business of the Life Insurance Examiner. Here the important factors are family history, especially as to longevity and the incidence of degenerative conditions, such as apoplexy, coronary disease, obesity etc.; age of the applicant, apparent as well as real, occupation and habits, nutrition, whether stout or lean, the condition of his organs and the height of his blood pressure. Apart from accidents there is one element we cannot estimate, i.e., his resistance to disease. We know some individuals pick up infection much more readily than others. This tendency cannot be measured or foreseen.

In acute illness the patient's age is of importance. A sound heart, kidneys, lungs and liver, may be the saving feature. Just how sound a heart is, however, we do not know until it is put to a test. We can judge only by the pulse, blood pressure, heart tones and the effect exertion has on it. Even then we may be disappointed. To base a prognosis on one of these is dangerous. As a matter of fact, to base a prognosis on any one symptom, such as high temperature, is poor judgment, although the laity attach great importance to this finding. In chronic disease it is imperative that we consider whether the illness admits of recovery, partial or complete. If of a fatal type we may give a guess as to the duration, based more or less on statistics. If not inevitably fatal the duration depends on the resistance and recuperative powers of the patient and the condition of the unaffected organs along with the probability of complications.

Rheumatic Fever

The prognostic consideration in rheumatism has to do with the degree of carditis which is present. All other symptoms clear up completely as a rule. Chronic joint disease is not a sequel of acute rheumatism. Even chorea may permanently disappear. It is therefore the heart damage which must be considered in giving a prognosis. This is difficult because the infection is invariably found in young patients and we know the great tendency of a recurrence. The rheumatic heart, once compensated, does not break down from work or strain. It is always fresh infection that does the damage, not only in children but also in adults.

Also must we consider whether the attack was mild or severe. Those showing only tachycardia without any obvious heart defect, or those showing only moderate left hypertrophy with a mitral regurgitation, can be classified as mild. On the other hand those showing severe lesions, such as mitral stenosis, pericarditis or aortic lesions must be considered in a different class. The mild cases generally do well. Severe ones often do badly. Patients who have been through one or two attacks of rheumatism without heart involvement

may get along even with a recurrence; their outlook is good as a rule. They should be guarded against colds and other minor ailments as much as possible. The severer cases are more prone to recurrence, which generally affect the heart, causing fresh carditis and a steady downward progression, especially with aortic involvement. Children with severe rheumatic heart disease develop relapse after relapse, are bedridden for longer and longer periods and finally succumb in youth or early adult life.

There are therefore many factors in a prognosis in rheumatism. Consideration of all of these is important and makes a forecast difficult. There is some evidence that within recent years there has been a lowering of the morbidity however, and also in the incidence of cardiac involvement.

Pneumonia

With the introduction of the sulphonamides in the treatment of pneumonia, we can give a much more hopeful prognosis then ever before. These agents have tremendously reduced the morbidity and greatly reduced the mortality. However, there are many variables influencing prognosis—all of which must be taken into consideration, not only concerning the disease but also the patient. The mortality varies considerably with age, preceding ill health, constitutional conditions, social conditions, type of infection and degree of resistance.

After the period of infancy the mortality is very low until early adult life when it rises steadily, with a peak after fifty years. Alcoholism, obesity, diabetes, nephritis and surgery all tend to increase the death rate.

In considering prognosis youth and good environment are favorable. Considering symptoms, cyanosis and delirium are not favorable. Bilateral involvement is frequently, not always, more serious. Falling blood pressure is bad, high temperature not necessarily so. A falling temperature with rising pulse and respiration is not good. Temperature, pulse and respiration running fairly parallel is better. Extreme restlessness and insomnia are unfavorable. A moist tongue, natural sleep and well taken nourishment are favorable. A high white count is generally favorable, with exceptions however. Other clinical signs are more trustworthy. With a white count of 30,000 or more, look for empyema or complications; a positive blood culture indicates a bad prognosis.

In the early stages of the illness prognosis is difficult. It is well to remember that Osler said, "Toxemia outweighs all other elements in the prognosis of pneumonia." In general a good prognosis can be given in childhood. Chances for recovery fall in adult life, especially past fifty. Lean patients have a better chance than stout. Temperate than intemperate. Even though it may be a self-limited disease, good treatment and careful nursing play a great part in the patient's recovery or death.

Coronary Disease

At present there is no prognosis more frequently asked of the physician than that in angina or coronary disease. With the high incidence of these conditions in the past few years and with the increasing interest in, and knowledge possessed by the laity about the early symptoms, and the frequently sudden fatal outcome it puts the doctor on the spot when asked for a forecast. In anginal attacks we must endeavor to ascertain whether or not we are dealing with a true or false angina. Physical signs may not help us here and angina ending in death (coronary) may occur without any physical signs. Symptoms may give more information than signs. Be it remembered that true angina is far more common in men than in women, generally occurs past middle life and often is found in those having arteriosclerosis and hypertension of greater or less degree, although this has many exceptions.

Functional anginal pain is much more commonly precordial than substernal and is far more common in women than in men. It may radiate down the arms or up into the neck. One meets it in women during the menopause or during emotional upsets. Also in cases with irritable hearts. It is generally brought on more by emotion than effort, which is the reverse of that seen in true coronary angina. Severity of pain may not be a guide because there may be severe pain in such cases, while fatal cases of coronary may have little pain or only a brief sense of constriction in the sternal region. The psychic state of the patient is important but a wise physician will be guarded in his statements because a hysterical condition may be super-imposed on true organic heart disease.

In true coronary disease a family history of early cardiovascular deaths is always important.

A good family history improves the outlook. A patient's mental attitude also is important. One who is optimistic and can face the situation courageously has a better fighting chance. He must be able to live within the limits prescribed by his doctor and follow orders implicitly. A lessened frequency of attacks is always hopeful. Such patients may survive for years and die of other causes. The prognosis in coronary disease is not as bad as it is thought to be. The severity of the pain is not always indicative of a bad prognosis. Sudden attacks coming on with rapid pulse, falling blood pressure, and evidence of shock are always serious. Increase in severity and number of attacks indicate a progressive narrowing of the coronaries; on the other hand a patient may survive quite a severe attack, lose all his anginal symptoms after some months of rest and be in excellent health for many years, living within prescribed limits.

Murmurs are of little importance in coronary disease. Most important are the size of the heart and aorta. A cardiogram may or may not be helpful in prognosis. Disturbances of rhythm are not good. Gallop rhythm means myocardial damage. I think a low blood pressure is unfavorable, though opinions differ on this point.

Syphilitic cases with aortitis and stenosis of the coronary openings are bad. There is no chance for collateral circulation to be established as may happen when the smaller coronary branches are diseased or occluded in nonluetics. Luetics rarely live more than a year or two.

Typical anginal pain sometimes is met in rheumatic heart disease, when the aortic valves are involved. The pain may be like coronary angina but the prognosis is different. Such cases generally die of congestive failure. In coronary disease therefore, it is best to say that in a severe attack life is in danger for some weeks, while emphasizing the good chances of recovery. In every type of case sudden death is possible. It should be made clear that saving the life is the first problem. What the outlook will be can only be decided later when the heart capacity can be judged. A return to work should never be entirely ruled out.

Diabetes

As in pneumonia with sulphatherapy, and pernicious anemia with liver, the prognosis in diabetes has tremendously improved with insulin treatment. In this disease the outlook is vastly influenced by the severity of the condition, the degree of intelligence and coöperation of the patient, the ease with which his blood sugar can be controlled and the proper adjustment of his insulin dosage when this is necessary. Many mild cases do not need insulin. Others may need small doses for a while and can then be controlled by diet. However, in any case a good prognosis may be upset by a recurrence of considerable severity or by the incidence of other diseases. How well we know the effect of only a common cold, a boil or any mild infection in the diabetic. He promptly loses his tolerance and needs insulin. Severe illness such as pneumonia in a diabetic should cause concern. It is always well to wait a year or so before giving any prognosis in diabetes. It is frequently a very mild disease in elderly people.

A patients' intelligence plays a great part in the success one has in controlling his sugar. Frequently well-informed people are the greatest offenders. They do not, or will not give the details of diet, insulin and urine testing the proper time and consideration, often with disastrous results. Others cannot resist the temptation to snitch a biscuit or ice cream cone, or some candy from time to time. In my experience treatment of the ambulant diabetic is often very discouraging. Under such conditions the disease progresses. Proper timing of meals and insulin is important. Constant changes are undesirable. Frequent blood sugar tests are not necessary. After all the presence of acidosis is the important finding and regular testing of urine should be done. If a case reacts quickly to insulin and there is constant danger of hypoglycemia it is permissible to allow a little glycosuria. A trace of sugar now and then does no harm.

Tuberculosis in diabetes is always dangerous. It requires a high caloric diet and large doses of insulin. Active tuberculosis in these patients calls for a poor prognosis. Pregnancy may make a diabetic worse for a while but can be controlled and generally the patient improves a few months after confinement.

The cardiovascular system in diabetes is a factor in prognosis. The presence of arteriosclerosis or atheroma is always cause for concern. The development of gangrene makes for a bad prognosis and we all know the frequency of coronary disease in diabetes. The prognosis, however, in

intelligent well-trained diabetics is good, all other things being equal.

Hypertension

There is considerable difference of opinion as to what constitutes pathological blood pressure. We all appreciate that the popular idea of 100 plus one's age is fallacious. In normal individuals there is not much variation in blood pressure readings between the ages of eighteen and forty. Systolic readings will average 120 to 130 going over 130 a few points at forty to fifty. One cannot lay down a rigid figure for blood pressure at any age. Blood pressure in a normal individual may fluctuate from day to day, depending on occupation, motional conditions, et cetera. In general it may be assumed that a sustained systolic reading over 140 must be taken seriously at all ages under sixty. The diastolic reading is infinitely more important than the systolic, e.g., 150/110 is much more serious than 180/85. Generally speaking, a sustained diastolic pressure over ninety is pathological.

Sound technique in taking blood pressure is imperative. A relaxed patient, accurate instrument, and proper surroundings, I need not mention. In any case of persistent hypertension we must first determine whether it is a case of only that, or whether the high reading is associated with other conditions. The most common is acute or chronic nephritis. Others are urinary obstruction and toxemia of pregnancy. Rarer ones are adrenal tumors, pituitary tumors, polycystic kidneys or coarctation of the aorta. Systolic pressure is often high in Grave's disease and aortic regurgitation, generally with a low diastolic, and in arteriosclerosis we often find a wide pulse pressure. There is also a definite menopausal hypertension with headaches, vertigo, tachycardia and vasomotor excitement. This may come before the periods cease and may endure for years after the last flow, although in general the outlook is favorable. Unless there are heart, arterial or retinal changes a gloomy prognosis should not be given such patients, who are generally emotionally quite unstable.

Again family history is of importance. If one of cardiovascular deaths it affects prognosis. In the personal history a past record of nephritis always is an event affecting the prognosis. Tobacco in excess is unfavorable. Alcohol I do not consider has much to do with high blood pressure. The younger the patient, the more serious the outlook. A severe hypertension in the thirties nearly always runs a rapid and fatal course. On the other hand if appearing in late middle life it may be symptomless for years. The outlook in an obese patient is not as good as in those of spare build. We must remember, however, that rapid loss of weight may be a symptom.

Thick arteries and a large heart makes the outlook graver within certain limits. More serious findings are gallop rhythm or auricular fibrillation although we see many cases which fibrillate but nevertheless maintain fair health for many years.

The presence of a little albumin is common but is not nearly as important as the specific gravity especially if this is constantly low and fixed. Impaired kidney function makes the outlook worse, especially when associatied with attacks of nocturnal dyspnea. Attacks of cardiac asthma are bad, although not necessarily fatal at once. Anginal attacks or "slight strokes" with mental changes and confusional states, make us fear further trouble.

On the whole hypertension is probably taken a little too seriously by the public and by some doctors. Very important in the prognosis is that degree of sanity which distinguishes the good prognostitian.

In general our batting average in prognosis is not too good. The eminent physician, Oliver Wendell Holmes, said, "To insure a long and successful life one should be pronounced incurably ill, in infancy, by three eminent physicians." That is too pessimistic a view, I am sure, and it may be we are at times in a pessimistic mood which affects our outlook on things. On the other hand we may be over-optimistic: There is no mathematical rule for making accurate prognoses. But who has such rules? How many of our experts in the Government predict accurately? How many predicted the duration of the last World War with accuracy? How many of our bankers and financial experts predicted the duration of the depression with accuracy? In general I believe the doctor is more sincere and frequently more accurate in his predictions than they were. Nature hides many secrets from us, perhaps for the better, and until we possess more light and understanding regarding individual resistance, it is difficult to forecast the day when any given patient will cease breathing.

The art of medicine plays a great role in mak-

(Continued on Page 48)

EDITORIAL

THE NEW YEAR

▪ We greet 1944 with the best of New Year's wishes for our members. The year just passed is history. Many things have been accomplished. Problems that seemed almost unanswerable have been solved. The shortage of doctors in our industrial and our critical areas has been met, and no one is reported suffering for lack of medical care. The men doing the practice during this time of stress are many of them overworked, but they are carrying on. Some have fallen by the wayside, going down in harness and doing their utmost to meet the heavy demands, but most are able to see it through. We look to the future with courage and determination.

The problems of 1944 will present themselves as they may arise, and will be met with the same fortitude and the same boldness that has characterized the past.

THE DOCTOR AND THE PUBLIC

▪ Public Relations is a term which may be applied to efforts of a group of people to sell themselves or their wares to the public with whom they must be on suitable terms of respect and confidence.

The medical profession has been one of the most progressive and altruistic in its dealings with its confreres. The past half century has seen such changes in the form and the means and methods of practice that it is scarcely believable. Our members know these things, and only marvel at the charge sometimes expressed by critics that we are still practicing medicine in the ancient and time tried ways of past centuries.

Only a few years ago we witnessed a studied and continued campaign to place the profession of medicine in an untenable position, and then we saw the accomplishment of some tremendous schemes. Were we not villified in the popular magazines and the "yellow press" as persons and groups with sinister purposes directed by a bureaucracy in Chicago? Were there not many articles written and published painting us and our ideals as unlovable?

Then came the indictment of the American Medical Association *et al* as in restraint of trade, as infracting the Sherman Anti-trust Law of dim and distant memory. It couldn't be—but it was. We were declared to be not a profession but a business league acting in restraint of trade in that we did seek to prevent a certain group from "selling medical services," as they wished to sell them.

Are we now going through another phase of this same deliberate attempt to seize the practice of medicine, as Thurman Arnold demonstrated to us he could do in the case of various other organizations? For years there has been criticism of the "archaic" practice where there is fee for service, and where there is also free choice of physician.

The Wagner-Murray-Dingell bills have been introduced, with all their intended socialization of not only medicine but all our free American life. There has also been the Children's Bureau Program for care of wives and infants of servicemen. The profession tried to influence that plan so that grants would be made to the wives to see them through an emergency, and make it cover other catastrophic expense, not just pregnancy. That plan was adopted by the House of Delegates of the American Medical Association, but how easily that was sidetracked! An appropriation had to be made in the summer to keep the service going because the calls were so many and so "unforseen." An amendment to make this money available to the wives was rejected.

Numerous articles are now appearing telling of criticism that applies to the medical profession in one way and another. One of the latest is in the American *Mercury* for November, 1943, "Horizons of Science," by Waldemar Kaempffert, entitled "What's Wrong with Medical Practice?"

"As an individual member of the community the general practitioner of medicine . . . is a decent fellow. . . . He tumbles out of bed at two in the morning to answer an emergency call, waits patiently for his bills to be paid and does an immense amount of medical good without charging anything. But when he attends his county medical society meeting he is a changed man.

(Continued on Page 46)

No Personal Freedom

In the November issue of the JOURNAL, I stressed the effect the Wagner-Murray-Dingell bills would have upon the Doctors of Medicine. We sat serenely by and allowed the Children's Bureau (Washington Bureaucrats) to slip over the Maternal and Infant Care program, an entering wedge in socialization of medicine. Now, before it is too late, let us inform the laity of some pertinent facts in this proposed panacea of social security, of this cradle-to-the-grave insurance.

We speak of the socialization of medicine, and immediately the laity thinks that we doctors are opposed to this bill for selfish reasons. Should the Wagner-Murray-Dingell bills pass, it would be the beginning of general socialization and there is no personal freedom under this. Does the American working man want Congress to vote the Government irrepealable power to tax his wages another 6 per cent in addition to the 20 per cent withholding tax (soon to be 30 per cent, it is said) plus 10 per cent for war bonds? This totals 46 per cent of the "take home" to say nothing of state and local taxes and union dues. If a worker wishes to take out insurance, as he should, against sickness, accident or death, there are reliable insurance companies to go to, not run by politicians. Under this plan, if times get tough, he can use his insurance premiums to better advantage for something else, he can cancel his insurance, cash any benefits which have accrued and keep his premiums. This cannot be done with cradle-to-the-grave insurance. That is compulsory insurance. It is here the worker gives up his liberty for the promise of security. These are a few facts we should try and make known to our patients.

C. R. Keyport

President, Michigan State Medical Society.

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President's



Page

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(Continued from Page 44)

His social outlook turns out to be that of the organization, which is to say that it is scarcely distinguishable from that of a plumbers' union. The medicine discussed is sound enough but the economics have nothing in common with what the people want. . . . The doctor votes solidly with his colleagues for the preservation of an economic status which is centuries old and which is unable to meet the needs of a new age. . . . The medieval system in accordance with which physicians must practice by the fiat of their national organization, which is the American Medical Association, is based on the principle of charging what the traffic will bear."

This is a seven-page article just as full of mal-information as these quotations from the first page.

Friday, November 26, one of our metropolitan papers carried a column about the status of the maternity-pediatric care of servicemen's families that was full of misinformation and placed the medical society in a very bad light. We have read many public statements of this controversy and none of them seemed to give a true picture of the situation. Is there a censorship that gets the wrong slant printed?

The *Journal of the Wisconsin State Medical Association* for November contained a page copied from the public press, and one squib alone was a whole lecture on the subject of public relations.

Are we witnessing a sustained and pointed invasion of our right to practice medicine in the progressive way that has developed such a fine health status in the United States? Are we doing enough to stem the tide that seems to have set against us?

HAVE WE A PROGRAM?

■ Michigan has been a pioneer state in many things. We have been leaders in the program of making postgraduate study possible to a vast majority of our members. We have been leaders in studying and trying plans for prepaid medical care. We helped through the years of our great depression and put the care for the needy during that time on scientific and socially sound grounds. As a society we have pioneered in one of the most gigantic sociological studies of the distribution of medical care the world has ever known.

For many years the profession has asked for a bureau of information to be maintained at Washington to picture the viewpoint of the profession of medicine. The experience of the past few years should have demonstrated the need of such a bureau, and the events that are now in process of happening show still more strongly the need of such a means of establishing public confidence before it is too late. We have been too late too many times, and after an action has been taken, whether by congress or by executive directive, it is then too late.

Last July at the summer meeting of the Council of the Michigan State Medical Society a pioneer meeting was held that should develop into a useful program for the dissemination of health education. Officials of the medical society, the state hospital association and the medical and hospital service association met with a few representatives of other kindred interests and discussed a program of coöperation and unity of purpose. A Council on Health has been established as a result. It is hoped that this move will lead to more tangible results.

One State Medical Association has made a very forward step and has provided funds to establish a source of contact with the Congressmen from that state in Washington. This seems highly imperative. Michigan could at least be second state to assure that our Congressmen have accurate and authoritative information before they take action on so many measures that involve the public health and care of our people, as well as the increasing restrictions and bureaucratic control over our methods of study and practice.

Our greatest protection is to keep the people informed of our problems, aspirations and the very forward methods of better distribution of the most scientific and progressive medicine that is now an object lesson to the world. This must be done before hampering and restricting or backward measures are adopted. Let us not be too late.

As we have suggested before we are in a revolution that cannot be stopped. Are we willing to allow this future of the health and welfare of our patients and ourselves to be guided by enthusiastic young highbrow economists who have already suggested or attempted to seize control of the medical profession, or do we wish this leadership and direction to be assumed by medically trained and experienced members of our profession.

YOU AND YOUR BUSINESS

COLLEGE OF MEDICINE, WAYNE UNIVERSITY GRADUATES FIFTY-EIGHT DOCTORS

On December 9, 1943 President Warren E. Bow conferred the degree of Doctor of Medicine upon fifty-three men and women at The Wayne University College of Medicine of whom forty-nine are enlisted men in either the United States Army or Navy. Three of the nine non-military candidates are women leaving six civilian men among the graduates.

BASIC SCIENCE BOARD OF EXAMINERS

Dr. Orrin E. Madison, associate professor of chemistry at Wayne University, has been re-elected president of the Michigan State Board of Examiners on Basic Sciences for the two years ending November, 1945. Arthur M. Chickering of Albion College was elected vice president for the same term.

AMERICAN BOARD OF OPHTHALMOLOGY

The American Board of Ophthalmology announces that the deadline for filing applications for the 1944 examinations are for New York City examinations in June, December 15, 1943. For the examinations in Chicago in October, the deadline is April 1, 1944. All applications received after January 1, 1944 will be subject to the increased total fee of $75.00.

VOLUNTARY HEALTH PLANS IN CALIFORNIA

In April and May, 1943, Mr. John R. Mannix of the Michigan Hospital Service conducted a survey of the voluntary health plans in California at the request of the California Medical Association. This report was published by the California Medical Association and is a twenty-page brochure containing numerous recommendations to improve the plans in California.

Primarily these recommendations are that the various plans there be consolidated under one more or less general management with representatives of the various plans on the controlling board.

The tenth recommendation is as follows:

"It is recommended that there be employed a public education director. This individual should have had experience in newspaper or related fields. It should be his duty to develop direct mail, newspaper and magazine releases and other material which would keep the employers and public throughout the State informed regarding the medical and hospital plans. Before, plans in the state have been weak in the matter of proper public education and public relations. Medical and hospital plans cannot be successful unless the public understands what they are attempting to accomplish and what they have to offer.

The final paragraph of the report reads, "California is the fourth largest state in the Union in population and unquestionably one of the most important. The future of the private practice of medicine and the voluntary hospital system may well depend on the success or failure of voluntary help plans in this state. California is in a position to make an outstanding contribution to the voluntary health plan movement and to the preservation of the private practice of medicine and the voluntary hospital system."

MENINGITIS IN MICHIGAN

Foreseeing a major epidemic of meningitis in Michigan next year, the state health department announces that it is distributing sulfonamides to health officers and physicians in anticipation of increased need.

There has been a gradual increase in meningitis over the last year. In normal years, the expectancy of meningitis during the hot months is zero. In recent months, however, meningitis has remained at epidemic level during a period when no cases could be expected on the basis of seven-year averages.

Meningitis is a "crowd disease" and the present increase is attributed to crowding in public conveyances and buildings, to increased travel from one section of the state to another and to mass migration to Michigan industrial areas from other states.

New sulfa compounds are aiding in the reduction of deaths from meningitis. Since there is no preventive of meningitis, such as vaccination against smallpox, reliance must be placed upon good personal hygiene, good medical care and avoidance of crowds so far as possible.

THE WAGNER-MURRAY-DINGELL BILLS

Referring to the Wagner-Murray-Dingell bills the *Michigan Times* says:

The doctor is our most private and personal servant. Since time immemorial he has served as an advisor, a helper and friend of the individuals who comprise the community. Inasmuch as Socialism tolerates no personal service, in fact, no personal contacts, it is quite logical that those who would change our form of government will begin at the very heart of the citizen's personal relationships. Confuse these relationships, instill them with prejudice, mistrust and suspicion, and the socialist will have an entering wedge into the body politic.

Grove Patterson, in *Toledo Blade,* September 2, 1943, discussing the Wagner-Murray-Dingell bills:

No doctor has asked me for my opinion about this and nobody has asked me to write about it. Frankly I am less concerned with the welfare of the physicians than I am with the tremendous stride toward the further regimentation of American life which will be taken if this bill is passed. Legitimate business has already been put in a rut. It is proposed to put the medical profession in a rut. Next, one profession after another will be put in a rut. And the only difference between

a rut and a grave is that the sides of the grave are slightly higher. But in time the rut will be deep enough.

The *Nation's Business,* October, 1943, says:

"Receive a free medical education from the Government while earning $50 a month" is the gist of the Army and Navy program to put 5,000 students a year through medical West Points and Annapolises. So vast is the contemplated permanent military establishment that Dr. Ross T. McIntire, surgeon general of the Navy, has estimated one-third of the more than 50,000 wartime medicos will not return to civilian practice.

Contrary to the impression created by the Washington Group Health Association case and the attendant antitrust suit against the AMA, organized medicine has not opposed voluntary health insurance. For several years it has been promoting this method for more widely distributing medical science. The medical societies of 38 states now have voluntary pre-payment plans in operation or are experimenting in that direction. More than 300 county medical societies are working on changes aimed at making preventive and curative service available to all, whatever their economic status. . . .

We should not assume that the whole margin between present care for the sick and unlimited perfection is chargeable to the doctors. The whole tendency has been to overrate the economic factor at the expense of another probably just as important—the public attitude toward medical science, particularly in its preventive aspects.

PROGNOSIS

(Continued from Page 43)

ing a prognosis. A proper understanding of the patient's psychology as well as his disease is of great importance. Osler said, "Medicine is of the heart as well as the head." We have all seen patients we considered practically hopeless, who had the will to live, and did. Boosting the morale of both patient and family never was bad practice.

A mistaken prognosis should not make us discouraged. We have many shortcomings. No one realized this fact more than Sir William Osler. When pondering on his failures he liked to believe Robert Louis Stevenson's beautiful tribute:

"There are men and classes of men that stand above the common herd; the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarelier still, the clergyman; the physician almost as a rule. He is the flower of our civilization (such as it is); and when that stage of man is done with, and only to be marveled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tried in a thousand embarrassments; and what are more important, Heraclean cheerfulness and courage. So that he brings air and cheer into the sick room, and often enough, though not so often as he wishes, brings healing."

Communications

L. Fernald Foster, M.D.
Secretary, Michigan State Medical Society
Dear Dr. Foster:

Thanks for your letter at hand informing me of my election to Emeritus Membership in the Michigan State Medical Society.

I consider this a very high honor and whether I merit it or not I am very grateful.

Length of service is one thing; quality of service is another. I have nothing but thanks to my Creator for this length of service and a Prayer to overlook the quality of it.

With kindest regards to you and best wishes for the welfare of the Michigan State Medical Society I beg to remain.

Very respectfully yours,

ROBERT L. SCHORR

Detroit, Michigan
Dec. 4, 1943

Claude R. Keyport, M.D., President
Michigan State Medical Society
Grayling, Michigan
Dear Dr. Keyport:

It has come to the attention of this office that physicians are being asked to sign blank birth certificates in the hospitals. Several cases have already been discovered where the information relative to a birth was put on a certificate signed by a physician who did not attend that particular birth. A practice such as this in a hospital may result in some very serious complications. Certainly, no physician wants his signature on a certificate of birth which he did not attend.

Your attention is further invited to the provisions of Section 12 of the Vital Statistics Laws which reads in part as follows:

"* * * A certificate of such birth shall be filed with the registrar of the district in which it occurred: Provided, however, that an illegitimate birth shall be filed with the state department of health and not with the registrar of the district in which it occurred. * * * It is hereby made the duty of the physician, midwife, or person acting as midwife in attendance at a birth, to file the certificate. *If no physician, midwife or person acting as midwife was in attendance,* it shall be the duty of the father or mother of the child, the householder or owner of the premises or the manager or superintendent of the public or private institution where the birth occurred, in the order named, to report such birth to the local registrar within five days thereafter:"

May we solicit your assistance through the state medical society informing physicians what is happening as a result of their signing blank birth certificates and ask that such a practice be discontinued. Your cooperation and assistance will be greatly appreciated by this department.

Very truly yours,

H. ALLEN MOYER, M.D.
Commissioner, Michigan Department of Health

Lansing, Michigan
Nov. 24, 1943

PROCEEDINGS OF THE MSMS HOUSE OF DELEGATES—1943

TABLE OF CONTENTS

	Introduction of Business*	Reference Committee Reports†
I. Record of Attendance	978	
II. Speaker's Address	979	55
III. President's Address	980	55
IV. Annual Report of The Council (including report of Committee on Scientific Work)	982	55
V. President-Elect's Address	984	55
VI. Report of Delegates to AMA	985	55
VII. New Business		
1. Address of M. S. Van Geisen, Flint	986	
2. Address of F. A. Brockenshire, M.D., Pres. O.M.A.	51	
3. Testimonial to Michigan Medical Men in Military Service	77	
VIII. Resolutions:		
1. Educational Fund (Springer)	987	65, 76
2. Wagner-Murray-Dingell Bills (Witwer)	988	76
3. "Institute on Public Health Economics" (Brasie)	989	71
4. To Change Form of Michigan Medical Service (Brasie)	989	76
5. To Limit Michigan Medical Service to Doctors of Medicine (Brasie)	989	71
6. Declaration of Medical Policies (McClellan)	989	65
7. To Improve Public Relations (Luce)	989	68
8. Special Memberships (Emeritus) (Brunk, Hafford, Wiley)	990,991	64
9. Taxes on Medical Homes (Gruber)	990	76
10. To Enlarge Field Activities of AMA (Gruber)	990	68
11. Assessment for Campaign of Public Information on Medical Care (McClellan)	990	65
12. Hospital Licensing Act (Christian)	991	67
13. AMA Bureau of Information (Christian)	991	68
14. Program of Obstetric-Pediatric Care for Servicemen's Wives (Oakes)	54	76
15. Activity of Red Cross (Gorsline)	55	71
IX. Amendments to Constitution and By-Laws:		
1. By-Laws, Chapter 8, new Section 4 Remission of Dues of Military Members (Hess)	987	To 1944 Session
2. Constitution, Article III, Section 4 Associate Membership for Physicians in Military Service (Hess)	987	60, 63
3. Constitution, Article III, Section 4 Memberships for Physicians Temporarily Retired (Hess)	987	To 1944 Session
4. Constitution, Article III, new Section 8 Life Members (Hess)	987	To 1944 Session
5. By-Laws, Chapter 6, Section 6 "Committee on Venereal Disease Control" (Hess)	988	59
6. Constitution, Article VIII, Section 2 Succession of President-Elect (Hess)	988	To 1944 Session
7. By-Laws, Chapter 2, Section 2 Order of Business, Officers' Night (Hess)	988	59
8. By-Laws, Chapter 6, Section 9 Duties of Ethics Committee (Hess)	988	60, 64
9. Constitution, Article III, Section 4 Membership for Physicians Temporarily Retired (Dutchess)	990	To 1944 Session
10. By-Laws, Chapter 9, Section 3 Qualifications for Membership (Dutchess)	990	61

*Page numbers from 978 through 991 refer to the December issue; others refer to this issue.

†Page numbers listed under Reference Committees' Reports refer to this issue.

	Introduction of Business*	Reference Committee Reports
X. Constitutional Amendments Presented in 1942		
1. Article III, Section 1, eliminating "Junior Members"	989	58
2. Article VII, Section 1, changing "meeting" to "session"	989	58
3. Article VII, Section 2, changing "registered" to "seated"	989	58
4. Article VII, Section 3, changing "registered" to "seated"	989	58, 63
XI. Reports of Standing Committees		
1. Legislative Committee	991	56
2. Committee on Distribution of Medical Care	991	56
3. Joint Committee on Health Education	991	56
4. Medical-Legal Committee	991	56
5. Preventive Medicine Committee	991	56
6. Cancer Control Committee	991	56
7. Maternal Health Committee	991	56
8. Syphilis Control Committee	991	57
9. Tuberculosis Control Committee	991	57
10. Industrial Health Committee	991	57
11. Child Welfare Committee	991	57
12. Iodized Salt Committee	991	57
13. Heart and Degenerative Diseases Committee	991	57
14. Postgraduate Medical Education Committee	991	57
15. Public Relations Committee	991	57
16. Ethics Committee	991	57
17. Mental Hygiene Committee	991	57
XII. Reports of Special Committees		
1. Conference Committee on Prelicensure Medical Education	991	57
2. Professional Liaison Committee	991	57
3. Postgraduate Extension Committee	991	57
4. Radio Committee	991	57
5. Committee on Medical Preparedness (name changed to "Committee on Procurement and Assignment of Doctors of Medicine")	991	57
6. Committee on Nurses Training Schools	991	57
7. Advisory Committee to Woman's Auxiliary	991	57
8. Beaumont Memorial Committee	991	
XIII. Program of Obstetric-Pediatric Care for Servicemen's Wives	52, 61	71-76
XIV. Reports of Reference Committees		
1. On Officer's Reports		76
2. On Reports of The Council		55
3. On Reports of Standing Committees		55
4. On Reports of Special Committees		56
5. On Amendments to Constitution and By-Laws		57
(a) Constitutional Amendments Presented in 1942		58
(b) Amendments to By-Laws Presented in 1943		58, 62, 63
6. On Resolutions		59, 60, 61, 63, 64
XV. Elections		64-76
1. Councilor of 11th District		77
2. Councilor of 12th District		77
3. Councilor of 13th District		77
4. Delegates to AMA		77
5. Alternates to AMA		77
6. President-Elect		78
7. Councilor of 16th District		78
8. Speaker, House of Delegates		79
9. Vice Speaker, House of Delegates		79
XVI. Adjournment		79

*In December, 1943, issue, with exception of Item XIII.

MICHIGAN STATE MEDICAL SOCIETY

Seventy-eighth Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

Statler Hotel, Detroit, Michigan

September 20, 21, 1943

(Concluded from December issue)

Tuesday Morning Session
September 21, 1943

The meeting convened at ten-thirty o'clock, P. L. Ledwidge, M.D., the Speaker, presiding.

THE SPEAKER: The House will please come to order. Is the Chairman of the Credentials Committee ready to report?

J. J. O'MEARA (Jackson): Mr. Speaker, I hold in my hand eighty-two credentials, 40 per cent of which are not from any one county.

THE SPEAKER: If there is no objection, this will constitute the roll call for this meeting, and I declare the session in order.

It is with great pleasure that I call at this time on Dr. Brockenshire from Ontario. He is President of the Ontario Medical Society.

VII-2. ADDRESS OF F. A. BROCKENSHIRE, M.D.

F. A. BROCKENSHIRE, M.D.: This year each association has come through with a visit at the other's meeting. I think it well perhaps that these two associations should attend each other's meetings, should see just how they behave in action, see what are their problems, and how they are attempting to solve them. For some years invitations have gone back and forth, but it happens that they have never been carried through. I believe it was quite some years, until your representative visited us in Niagara Falls last May, and it happens that I am here with you at this meeting.

Actually, our problems in Ontario are almost identical with yours, more so perhaps than are the problems of some of your other border states, or even our bordering provinces. We, too, have much the same type of setup that you have, with an industrial lower portion of the province, set in a farming community, and the mining and lumbering industry in the northern section of our province, which in our instance reaches clear up to the Manitoba border.

Now, in our setup on the other side, it is really quite a happy setup. Our Ontario Medical Association, an active and a voluntary association, as yours, has close to 2,400 members out of a present active membership in the province of about 3,400. We have about 1,400 in the Army.

Our relationship with our Canadian Medical Association is a very happy one. Our Canadian Medical Association is really a central body, set up by confederation of our provincial body. In itself, it has practically no membership. Its membership is drawn from the provincial associations. That is carried so far that each province in this confederation is really known as that province division of the Canadian Medical Association. For instance, we have in Ontario a double-barreled name. We are the Ontario Medical Association or the Ontario Division of the Canadian Medical Association.

I may say that we even carry that a bit farther in Ontario, in that for some years we have followed the precedent of appointing as members from Ontario, on the Board of Directors of the Canadian Medical Association, the President-Elect, the President and the Past President of our Provincial Association, so that you can see our tie-up is really very close.

Now, when we, on our side, take a look at how medicine is going, what progress we are making, we feel rather happy at many of the things that have occurred, what advances we have made. Like yourselves, for instance, when we take a look at mortality figures, we feel very happy. But that does not with us seem to be the whole question. It does not seem to be the whole answer, and pretty fresh in the minds of many of us on our side is our last depression, when there were many vacant chairs in every doctor's waiting room. Today in every doctor's waiting room there are not enough chairs to hold the people who line up against the wall and sit on the window sill and the radiator. They stay all afternoon to see the doctor.

There are many reasons for that, but one of them was the cold fact that we eventually had to appreciate, that when people didn't have money they were rather loath to go to the doctor. We were perhaps a bit slow in appreciating that, but for some years it has been driven in to us more and more, and on our side there is a constant pressure that is increasing. It is a pressure from, I would say, two sources, from the people, particularly from Organized Labor, to a very slight extent from organized agriculture, and again from members of the Departments of Health throughout our country, who, as they look at the statistics year by year, feel that still further improvements could and should be made.

From those two sources, we are under constant pressure to establish some change in the method of obtaining or paying for medical service.

Fortunately, our relationship with both Departments of Health, with governments on our side, is a very happy relationship. This pressure reached the stage last year that a tentative bill for health insurance was formulated by a committee of our Dominion Government and was last year presented to a parliamentary committee for study. No action was taken on it. It was referred back to another committee this year.

The thing that strikes me in all of it is that while pressure is coming on us from recipients and from departments of health, to rearrange the method by which people may obtain their medical service, these people seemingly think that they can set up a scheme and administer it, that there is no problem in that at all, that the problem is just to establish it, and from there on it will work and run. But we in medicine have no such feeling. We feel that while you can state the problem quite simply, the answer to that problem and the organization of such a scheme is not simple at all, and we have a feeling that neither these lay groups nor departments of health are liable to solve that administration and set up a scheme which will be workable and satisfactory to ourselves or to the public who will receive the service.

We have a very distinct feeling—I have a marked suspicion—that if we are not happy, the public are not liable to be very happy either.

There are many problems being brought up and discussed, but we think many problems are in such a scheme. We think we want to know pretty much in detail just how service under such a setup would be rendered. We would like to get right down to "Mrs. Smith is sick over on such-and-such a street, who calls Dr. So-and-So to see her." We would like to know, step by step, what Mrs. Smith has to do to obtain her doctor and to obtain her service, how she is going to pay for all that. We want to know particularly just how that doctor, what he has to do, what moves does he have to go through, between his call to see her, his reporting, and his eventually receiving remuneration. We want to know that step by step.

We have a very distinct feeling on our side that we don't like any central type of administration. We have a thought that up to date, on our side, the thinking has been too much at the top and not enough down on that street where Mrs. Smith lives, down in that locality. We feel that most of the thinking has been top-heavy, that a roof has been built, set away up here, but there is very little foundation underneath it. We feel that we need to do some thinking down at the bottom and build it up, instead of from the top and build it down.

In civilian life, we do not react very well to a policy of dictation by any central authority. We have a feeling that we want a very distinct and very large say in the management of our own affairs. The problems that are going to be presented are medical problems, and we feel that no layman—and we doubt whether civil servants who have been long out of practice are liable to adequately solve those problems. We have a feeling that the onus is on us. If we want this job done well, it is incumbent upon ourselves to think it out, think out the detail, and work it out.

It has often been suggested that we should hire somebody, but my own contention is that you cannot hire somebody to think for you. We must think. Far be it from me to say what you should do, but we must do our own thinking. We can hire people to do the detail work.

Mr. Speaker, I am very happy to be here. To all of you, I bring greetings from the Ontario Medical Association. I hope this coming year, when we hold a meeting—our next meeting is in Toronto—unfortunately our meeting this year is in conjunction with the Canadian Medical Association and we will hold only a business meeting of our own, but invitations will be sent across to your Association. I hope we may have the pleasure of your company.

THE SPEAKER: Thank you, Dr. Brockenshire.

We have with us another gentleman, a friend from Ontario. Time prevents our calling on him for a talk. I am going to ask him to take a bow. Dr. J. W. McCutcheon, the Secretary of the Ontario Medical Association of Toronto. Dr. McCutcheon.

(Dr. McCutcheon rose. Applause.)

XIII. Program of Obstetric-Pediatric Care for Servicemen's Wives

THE SPEAKER: At this time we will carry out the announcement that we made last night, that Dr. Moyer would be here to give us a little advice on the obstetric-pediatric program. Dr. Moyer has been in a difficult position. He is one of our own men, who has been in general practice for a great many years, and we want to show him every respect.

We also have felt, as I said last night, that perhaps most of the responsibility is in Washington. We invited Dr. Moyer to address the House of Delegates, and upon his suggestion, we invited Dr. Dailey of the Children's Bureau of Washington, to be here.

I tell you these things because I think they should all be on the line before we ask Dr. Moyer to make any remarks.

I called Dr. Dailey in Washington last Tuesday. His office said that he would not be back until Thursday. I called him twice on Thursday. He still was not back. On Friday we did get in touch with him, told him that Dr. Moyer had suggested inviting him, and we were very happy to do so. He said, unfortunately he could not come, that he had to appear before a congressional investigation of some kind.

He wanted to know what the trouble was up here. He suggested that we were having good coöperation, some 900 doctors having signed blanks. I told him that was perfectly true, that 900 doctors had signed blanks, that we had about 3,500 in practice, and we felt we were not having good coöperation that such a plan should have, if it were properly set up.

He said, "What's the trouble?"

"Well," I said, "there were two or three. The first trouble is the direct payment to physicians."

He said, "There is a ruling on that by Solicitor Haggs of the Department of Labor. That cannot be done under the law."

The next thing we asked him was, "Why not permit these individuals to have hospitalization and to make their own arrangement with their physician, in keeping with what has been our custom? Is there a ruling on that?"

He said, "There has been no ruling on that point."

We asked then, "May we have such a ruling?"

He said, "Certainly."

After talking with him, and hanging up, I got to thinking that perhaps the ruling wouldn't be here in time for our meeting, so I sent him this telegram:

Pursuant to telephone conversation of this morning, please wire collect, not later than 11 a.m. Tuesday, September 21, legal opinion on this point, naming authority giving opinion, is it possible for the wife or infant of an enlisted man treated as a private patient on a new basis to receive hospital benefits under the Obstetric-Pediatric Program? In other words, may a patient take advantage of the hospital phase without the medical? A favorable decision on this point would lessen our problem in Michigan very materially.

I have just received a telegram at this moment. That is why I am reading it here instead of taking it up with Dr. Moyer personally: (This was wired last night.)

Information requested your wire September 17 will be wired to Dr. Moyer.

It is a great pleasure to call on Dr. Moyer at this time. Dr. H. A. Moyer of the Michigan Health Department.

H. A. MOYER, M.D.: There has been a great deal of confusion about this question. I think practically every one that knows me realizes that I have been a practitioner here in the state of Michigan for forty years, and that at no time have I ever advocated socialized medicine or anything in that line.

Now, this bill came up, was passed by the Legislature, given to the Labor Department, and they, to the Children's Department, Maternal and Child Health, to see that this money was distributed throughout this United States.

Then came an interpretation of that law from the United States Attorney Biddle, that said that no discrimination could be used in any way in who was eligible to perform this work.

I immediately appealed to our local attorney general,

so that we would have the law as it is in the State of Michigan, whether the osteopaths were entitled to participate in this policy.

I have here in this briefcase his opinion, which says that they are entitled to participate in this plan.

Now, there are many questions that have arisen as to different things pertaining to this bill.

I think that the Legislature, when they passed this bill, had the idea that if a person was well enough, we will say "heeled with money," that he would not participate in this plan, because it specifically says in the law that they must accept ward care, and I think that was the way that they figured that those that were financially able to pay the practitioner and take care of the hospital bill would do that rather than be compelled to go into the ward. That ruling still holds good.

Now I think that the Speaker of the House has brought this question up to you very markedly, stating some of these facts as they come up. I will say that the Governor met with the delegation of the Wayne County Medical Society. I don't know what transpired, but I was in the Governor's office yesterday, and they requested me to meet with the committee of the Wayne County Medical Society today, before this meeting, and to try to iron out some of these points that came up, that they did not like, which I did this morning. I met with Dr. Insley, Dr. Chandler, Dr. Hull and Dr. Barrett. They seemed to think that the question placed at the head of this request for authorization should be changed to read: "the certification of need for emergency hospital, maternal and infant care."

I agreed with them that it would be O.K., and I will do everything in my power to have that ratified, if that is their wish.

Then, lower down, where it requests the authorization for payment and so forth, erase that and in its place they wrote: "I agree to provide emergency maternity and infant care to the aforementioned applicant."

That means, gentlemen, those that wish to do this work gratis, that is their privilege.

Then it goes on, lower down, the second point of that: "I elect, or do not elect, to accept the Federal payment stated below." And that stated below is that the prenatal care, $2 a visit up to $10; delivery and immediate postparturient care, $25; and postparturient examination, $20; making the total $40. I agreed to that.

Now, if those are the questions that are blocking this situation, I am very happy to correct that as to the wishes of this delegation.

Now, as far as the question that came up in this telegram, I have not received that telegram, but I will say this, gentlemen, that those that wish to do this work, if they will so state on that, instead of requesting the certification, as they wish it stated, that they wish to do that gratis or any other way and for us to furnish the hospital bill I am O.K. with that, too, and I will see that that is put through.

Now, I don't know of any other questions. If someone wants to ask a question or something in that line, I would be very happy to do the best I can to answer it.

THE SPEAKER: Dr. Moyer, may I ask you one question on that?

In the telegram, copy of which I have here, which you may have if you wish, we asked this question: "Is it possible for the wife or infant of an enlisted man treated as a private patient on a fee basis to receive hospital benefits under the Obstetric-Pediatric Program?" That is the question.

Dr. Dailey told me that there had been no ruling on that. On our plan, up to the present, we have not been accorded that privilege. I know it was Dr. Smith's understanding that it was not permissible. So if you get that telegram today, I wonder if we may have it before this meeting closes?

DR. MOYER: Sure. I would be very happy, but I can assure you that that will be granted, that the hospital care will be taken care of, and those that wish to take care of that patient for nothing, gratis, or anything in that line, it is satisfactory to me.

But I want that record, gentlemen. That is what I am out after, to keep the record. I think that is what the intent of the bill was, that we could have a more marked record of these cases, as to the care and so forth.

THE SPEAKER: Are there questions now that you would like to ask Dr. Moyer? I ask you, in asking your questions, to keep these things in mind. Dr. Moyer is one of our honored members, as I said before, who has done general practice a great many years. He is with us. He wants to do everything he can to help us. So keep your questions with that in mind.

D. R. BRASIE, M.D. (Genesee): Dr. Moyer, it is our understanding that this same question that you have answered was brought up once before in private conversation with, I believe, a gentleman by the name of Sanders, who is a Regional Director of some sort under this setup in this region, and that he agreed that such things might be done, and yet, on July 28, there came a ruling—it is my understanding—from the Child Welfare Bureau, that they could not accede to this same question that is now proposed and that you are agreeing to do.

The question is, Dr. Moyer, in all due respect to you, sir, have you the authority to state that and make it stick?

H. ALLEN MOYER, M.D.: I will make this statement to you, gentlemen, one and all, that I will do everything in my power to put this through, and I am practically assured, from one of the representatives of the Children's Department yesterday, that that is O.K. to do.

D. R. BRASIE, M.D.: May we ask, Which one?

H. ALLEN MOYER, M.D.: If I can get this telegram, it will absolutely settle that question, once, last and for all. I am fighting and doing everything possible, that if you gentlemen wish to do this gratis or on the free basis, as far as caring for the mother is concerned, all right. According to this, you may elect or not elect to receive the fees below, and in case you do, we will take care of the hospital bill. I can practically assure you of that statement.

Things change, as things come up throughout the different states, but I will acknowledge this, that I have no positive ruling as to that more than the verbal statement made yesterday in my office. But I can practically assure you that that will be done. If it is not, you will be made aware of it immediately.

THE SPEAKER: Are there other questions?

DON V. HARGRAVE, M.D. (Eaton): You stated the disposition of the osteopath. What disposition has been made of the chiropractor?

H. ALLEN MOYER, M.D.: Yes. The chiropractors in the state of Michigan are not recognized, but the osteopaths, according to the attorney general's ruling, I am compelled to recognize, much to my sorrow.

THE SPEAKER: Are there further questions?

H. ALLEN MOYER, M.D.: I wish to say, in regard to the osteopaths, that we are going to try, and we are laying down rules, and no one that goes over recent graduation from an accredited college is going to be recognized in taking care of these cases. The hospitals are going to be inspected, and that whole line is going to be taken care of from a general practitioner's standpoint.

D. R. BRASIE, M.D.: Inasmuch as midwives are recognized in this state, may I inquire as to whether or not, in this program in the state of Michigan, midwives are recognized?

H. Allen Moyer, M.D.: We do not recognize midwives in this work.

A. F. Jennings, M.D. (Wayne): What about osteopaths in the hospital?

H. Allen Moyer, M.D.: Just a little bit more explicit, please, as to what you mean there.

A. F. Jennings, M.D.: Are the osteopaths to be admitted to general hospitals under this program?

H. Allen Moyer, M.D.: The osteopaths are not allowed in the regular hospitals, if that board so rules. They will have to take care of their patients in their own osteopathic hospitals.

A. F. Jennings, M.D.: Can they refuse to admit osteopaths? Can a hospital refuse to admit osteopaths?

H. Allen Moyer, M.D.: Yes, sir, they have that right.

The Speaker: Are there further questions?

L. J. Hirschman, M.D. (Wayne): I saw in one of the newspapers, within the last three or four days, the attorney general of the State of Michigan had ruled that osteopaths under the law, are not allowed to prescribe medicines, expecting narcotics for the relief of pain. Is that true?

H. Allen Moyer, M.D.: Not according to the opinion of the attorney general. They have a right to prescribe and perform surgery or such things as they were taught in the college at the time that they graduated, according to the curriculum in the college from which they graduated.

L. J. Hirschman, M.D.: I saw this ruling this week, where the attorney general had made that ruling, not regarding surgery or obstetrics, but that they were not allowed to prescribe medicine excepting narcotics for the relief of pain. I wondered if you knew of such ruling.

H. Allen Moyer: I have no ruling of that kind. From our own local attorney general?

L. J. Hirschman, M.D.: Yes, check that up.

H. Allen Moyer, M.D.: That has not come to my attention. It has not been delivered to my office. I am pretty sure it would have been had that opinion come through officially. I don't say it didn't, but it hasn't come to me, and anything pertaining to medicine, he has been very, very nice, and sent me a copy.

A. T. Hafford, M.D. (Calhoun): Does this maternity plan apply only in hospitals, or can it also be taken care of in the home? In other words, if an osteopath wants to take a case in a home, can he be paid under this plan?

H. Allen Moyer, M.D.: This plan, according to the setup, pays for the care, if they wish to be delivered at home. In the northern part of the state we have not hospitals sufficient to deliver them, and we are furnishing nursing care with those cases, in that sparsely settled region. We have taken that into consideration, and those that wish to deliver a person at home have nursing care at the home.

L. J. Hirschman, M.D. (Wayne): I have the information that I was trying to get across a few minutes ago. This was telegraphed from Lansing, Lansing Bureau of *Detroit News*. Here it is.

Osteopaths have no general right to administer or prescribe drugs for internal human medication, according to the Attorney General, Herbert J. Rushman, today informed Detroit OPA in response to request. He said, however, they may administer narcotic drugs for the relief of pain. The opinion was sent to Harland B. Christian, Chief Rationing Attorney.

H. Allen Moyer, M.D.: I know nothing whatever about that ruling, more than what the ruling has been and his recent ruling on whether they were permitted to participate in this policy. I would be very glad to look that up and get that ruling and see if it is true or not.

W. B. Harm, M.D. (Wayne): Is it possible, under this setup, for a hospital to certify to take care of these people, such as the University of Michigan and some of the other hospitals, to take confinement cases and care for them by their staffs?

M. Allen Moyer, M.D.: Yes, it is.

W. B. Harm, M.D.: Isn't that a hospital practicing medicine?

H. Allen Moyer, M.D.: I don't know. I wouldn't say as to that. They have to have their personnel. In order to accept that patient, that hospital has to receive the application from a doctor, that he will care for the patient, just the same as you would a patient in any other hospital.

The Speaker: Are there further questions?

J. A. Kasper, M.D. (Wayne): A question was asked here, just now, as to whether or not the hospital can contract to take care of the case delivered in hospital care for the sum of $60, provided that someone on the hospital staff will take care of the case.

H. Allen Moyer, M.D.: That question, I am not positive I can answer right now, according to Hoyle. The thing is that they must have the application of the attending physician in order to go to that hospital. If, for instance, something happened that the attending physician was not able to attend to that patient, the intern might. I wouldn't say he couldn't. But that is something between the hospital and the attending physician entirely, I think. I know there are cases where the prenatal care has been handled by one physician and they have sent it in to a hospital and some other doctor has delivered the woman. He received the $25 and the prenatal care goes to the attending physician, and the one who has the postnatal care gets the pay for that, as far as that is concerned.

W. B. Harm, M.D.: I don't think the hospital would allow the resident to serve an employe of the hospital. We are not talking about the attending physician, but the resident on the staff or resident on obstetrics. I don't think he could serve and the hospital collect the entire fee, not only the hospital fee but also the physician's fee. What we are trying to find out is whether this Act will sanction the hospitals' practicing medicine.

H. Allen Moyer, M.D.: Personally, I do not feel that the hospital can collect the whole $105, if they stayed there ten days, but that is a question I will be very glad to take up and have the question answered sometime today. I will be glad to take that up with Washington and have the answer.

The Speaker: Are there any other questions?

If not, I want to thank you, Dr. Moyer, for coming today and for your very thorough answers.

We will go to unfinished business. Is there any unfinished business from last night? Any further resolutions?

VIII-14. RESOLUTION RE PROGRAM OF OBSTETRIC-PEDIATRIC CARE FOR SERVICEMEN'S WIVES

E. A. Oakes, M.D. (Manistee): We have a resolution that should have been presented last night, that I wish to present now. This is not my own resolution, but it is a resolution that should be presented to the House in order to bring the matter up for consideration. That is a resolution regarding the program of medical, nursing and hospital maternity and infant care for wives and infants of certain enlisted men.

Whereas, The Federal Government has established, through the United States Children's Bureau, a program of medical, nursing and hospital maternity and infant care for wives and infants of certain enlisted men in the armed forces of the United States;

Whereas, Under this program, a subsidy is paid by the government direct to Doctors of Medicine and not to the recipients of these services—which is an unsound principle, one which produces regimentation and a poor quality of service, and

WHEREAS, The establishment of this precedent makes possible a broader program leading to a system of complete federalized medical practice; and

WHEREAS, Such an acceptance of this program would commit to this type of medicine the 1851 Michigan Doctors of Medicine who are now in military service; and

WHEREAS, While the original need for this program was questionable, the inauguration of the project with the attendant surge of publicity, has stimulated a demand for this "Free" federal assistance; and

WHEREAS, Assistance under this program is not based on the establishment of economic need, which leads to cases of needless waste of tax funds; and

WHEREAS, This program represents a definite usurpation of State Rights by a federal bureau; and

WHEREAS, Partial acceptance of the program in its present objectionable form has been precipitated by those Doctors of Medicine, who, heedless of the advice of the Michigan State Medical Society as expressed in its letters of June 17 and July 28, have signed applications in great numbers; and

WHEREAS, Due to this partial acceptance by individual Doctors of Medicine, to local conditions in certain areas of our state, to lack of definite direction by the American Medical Association, to previous acceptance of the program by other states, and to the tremendous political pressure behind the project, some Doctors of Medicine are now finding it embarrassing not to participate in the plan; therefore, be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society approve a program of medical, nursing and hospital maternity and infant care for the wives and infants of certain enlisted men in the armed forces of the United States, if the program is based on direct grants to the recipients, if such federal funds are to be used by said recipients as necessity requires, if the physician-patient relationship is maintained, and if the program ends six months after the termination of the present war; and be it further

RESOLVED, That the House of Delegates of the Michigan State Medical Society disapprove and oppose this program so long as it embodies direct payment or subsidy to Doctors of Medicine, and be it further

RESOLVED, That for the reasons enumerated in the preamble, the decision be left to each service man's family and to each Doctor of Medicine to decide whether they will wish to participate in this federal (socialized medicine) program for the duration of the war; and be it further

RESOLVED, That the House of Delegates of the Michigan State Medical Society respectfully request the American Medical Association, through its new Council on Medical Service and Public Relations, to use its influence to effectuate a change in the present program as legislated by the United States Children's Bureau; and be it further

RESOLVED, That the House of Delegates urge all component county societies and all members of the Michigan medical profession to continue contact work and efforts with Michigan Senators and Congressmen in Washington, D. C., to counteract the gradual intrusion of State Rights, exemplified in the United States Children's Bureau program of maternity and infant care.

THE SPEAKER: This resolution will be referred to the Resolutions Committee.

VIII-15. RESOLUTION RE ACTIVITY OF RED CROSS

C. S. GORSLINE, M.D. (Calhoun): The inspiration for this short resolution was an incident that happened in our own local Red Cross Chapter, which apparently had been under the influence of a saleslady who was trying to put the matter across. The executive secretary in this meeting said she could not understand why the doctors objected to the plan.

This may be an isolated incident, but, thinking that possibly it was more prevalent than I knew, I wish to offer this resolution.

WHEREAS, The proponents of the Federal Program of Obstetrical-Pediatric Care for the wives and children of service men are making every effort to carry out the provisions of their program, even to inspiring criticism of the organized medical profession by local Red Cross Chapters, therefore, be it

RESOLVED, That this House of Delegates instruct the Council of the Michigan State Medical Society to make sufficient investigation to determine if such attitude of local Red Cross Chapters is sanctioned by Red Cross Headquarters, and if it is not so sanctioned, to ask that orders be issued to local Red Cross Executives to cease such criticism of the medical profession."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

Is there any further old business? Any further resolution? Any new business?

According to our Constitution, new business will have to be brought up at this meeting.

Then we are ready for the reports of the Reference Committees.

XIV. Reports of Reference Committees

XIV-1. ON OFFICERS' REPORTS (II, III, V, VI)

First on the program is the Report of the Reference Committee on Officers' Reports. Dr. Springer.

R. A. SPRINGER, M.D. (St. Joseph): Mr. Speaker, the Committee on Officers' Reports has reviewed the Speaker's very excellent address and find it is in agreement with the sentiments expressed and the recommendations contained therein.

I move the acceptance of the Speaker's Address.

WILLIAM J. STAPLETON, M.D. (Wayne): I second the motion.

(The motion was carried.)

R. A. SPRINGER, M.D.: The Committee on Officers' Reports has reviewed the President's Address and finds itself in agreement with the address as a whole, which we feel is a very comprehensive report of his stewardship during his term of office, and we feel satisfied that the House of Delegates will take such action as will put into practice many of the recommendations which he has made.

Mr. Speaker, I move the acceptance of the President's Address.

WILLIAM J. STAPLETON, M.D.: I second the motion.

(The motion was carried.)

R. A. SPRINGER, M.D.: The Committee on Officers' Reports has reviewed the President-Elect's Address and finds it is in agreement with the address as a whole, and we feel that the sentiments expressed assure us of competent, aggressive leadership during the year.

Mr. Speaker, I move the acceptance of the President-Elect's Address.

(The motion was seconded and carried.)

R. A. SPRINGER, M.D.: The Committee on Officers' Reports has reviewed the Report of the Delegates to the American Medical Association, which also has been approved by the Committee. We congratulate the Michigan Delegation for their usual outstanding, competent handling of the State Medical Society's interests, and for their upholding of traditional medical practice, and their opposition to further encroachment of Bureaucratic agencies upon the time honored patient-physician relationship.

Mr. Speaker, I move the adoption of the Report of the Delegates to the American Medical Association.

(The motion was seconded and carried.)

HENRY A. LUCE, M.D. (Wayne): Mr. Speaker, I move the acceptance and adoption of this report as a whole.

WILLIAM J. STAPLETON, M.D. (Wayne): I second the motion.

(G. Howard Southwick, the Vice Speaker, took the chair.)

(The motion was carried.)

THE VICE SPEAKER: Is the Chairman of the Reference Committee on Reports of The Council ready to report?

XIV-2. ON REPORTS OF THE COUNCIL (IV)

E. R. WITWER, M.D. (Wayne): Mr. Speaker and Members of the House of Delegates: Your Committee approves as a whole the report of the Council as submitted in the Handbook as well as the supplementary report read by the Chairman of the Council at the meeting, Monday evening, September 20, 1943. The subject matter covered in these reports, however, is of such importance that your Committee feels some of the points require emphasis and elaboration.

You have your Handbooks. I think it will be easier

if you follow the reports as submitted there. We have condensed our remarks in just a few pages, whereas the entire report of the Council covers about twelve solid pages of printing.

May we take this opportunity to emphasize, first of all, the establishment of a post-war, post-graduate medical education program. It is suggested that the officers and Council take every necessary step to insure the satisfactory and adequate development of such a program.

The matter of the creation of a fund to educate the children of deceased physicians was laid over from the 1942 meeting. It is the considered opinion of your Reference Committee that if such a fund were established it would create an insurance agency within the Michigan State Medical Society and would establish a precedent that would be undesirable. Your Committee approves action of the Council in this respect. The Council has postponed any commitment on a group disability insurance program. This should meet with the approval of all members of the House.

Recommendations Made by the Council

Your Reference Committee approves, without comment, Recommendations 1, 2, 3, 6, 7, and 8.

Regarding Recommendation No. 4, the Committee urges that every effort be made to negotiate an immediate revision of fees so that members of the Michigan State Medical Society may be compensated on a more equitable basis for their services rendered under the Crippled Children's Act and the Afflicted Adult Act.

Regarding Recommendation No. 5, may we emphasize particularly that every effort be made by the Council and other agencies of the Michigan State Medical Society to the end that Section 6 of the Basic Science Law be vigorously enforced by the proper authorities.

Regarding Recommendation No. 9, this deals with the Wagner-Murray-Dingell Bill (S-1161). A resolution pertaining to this bill was introduced in the House of Delegates on Monday, September 20, 1943. Your Committee urges the support of this resolution to all proper and necessary agencies of the Society.

Supplementary reports of the Council, as read by the Chairman, indicate that since the formal report was submitted for publication there have been many important matters considered by the Council.

The careful and conscientious consideration which your Council has given to the Obstetric and Pediatric Program for Wives and Infants of men in the service is worthy of our commendation. As a committee, we heartily concur in the recommendations made in the supplementary report, and we wish to emphasize that the medical profession must take all necessary steps to counteract the gradual intrusion by bureaucraitc agencies in the practice of medicine. Failing in this effort, the individual physician will soon lose his status if not his individuality. Every member of the Michigan State Medical Society should realize the importance of this particular problem.

The Council in the supplementary report has given careful consideration to the advisability of levying an assessment or increase in the dues to meet the depleting treasury fund. This in part is the result of many of our members being excused from payment of dues because of service in the armed forces. Your Committee feels that the recommendation of the Council should be approved, particularly in view of the fact that now, as never before, the medical profession must take necessary and immediate steps to establish suitable medical representation in Washington, the purpose of which should be the protection of the individual practitioner's interests.

The very excellent report submitted by the Council indicates that very careful study and consideration have been given to many delicate problems pertaining to the protection and furtherance of the interests in the science of medicine. To those of us who are entrusted with the discharge of duties as practitioners of medicine, the report offers a constant challenge and every member is urged to review it in detail.

The Committee recommends a vote of thanks to the members of the Council for their untiring efforts.

Mr. Speaker, I move the acceptance of the report.

William J. Stapleton (Wayne): I second the motion.

(The motion was carried.)

The Vice Chairman: Is the Chairman of the Reference Committee on Reports of Standing Committees ready?

(P. L. Ledwidge, M.D., the Speaker, resumed the chair.)

XIV-3. ON REPORTS OF STANDING COMMITTEES (XI, 1 to 17)

L. W. Day, M.D. (Hillsdale): Mr. Speaker, the following is the Report of the Reference Committee on Reports of Standing Committees.

Your Committee approves the Report of the Legislative Committee as written in the Handbook, and wishes to commend expressly the members of this Committee for their zeal in protecting the interests of the people's health during the 62nd Session of the Michigan Legislature.

I move the adoption of this report.

J. A. Kasper, M.D. (Wayne): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Your Committee approves the report of the Committee on Distribution of Medical Care as written in the Handbook.

I move the adoption of this report.

R. V. Walker, M.D. (Wayne): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Your Committee approves the report of the Michigan State Medical Society representatives to the Joint Committee on Health Education, as written in the Handbook.

I move the adoption of this report.

C. D. Brooks, M.D. (Wayne): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Your Committee approves the report of the Medical Legal Committee, as written in the Handbook.

I move the adoption of this report.

(The motion was seconded and carried.)

L. W. Day, M.D.: Your Committee approves with much appreciation the report of the splendid work performed by the Preventive Medicine Committee during the past year as written in the Handbook. I move the adoption of this report.

William S. Gonne, M.D. (Wayne): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Your Committee approves the report of the Cancer Control Committee as written in the Handbook.

I move the adoption of this report.

Robert L. Wade, M.D. (Branch): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Your Committee recognizes the controversial issue of the federal program with which the Maternal Health Committee was faced during the past year and agrees this issue is a matter for the State Society as a whole. The report as written in the Handbook is approved by your Committee. I move the adoption of this report.

E. A. Oakes, M.D. (Manistee): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Your Committee cannot approve the report of the Syphilis Control Committee as written in the Handbook without further clarification of Paragraph 2, Page 65: "The preparation of a prophylactic kit, considered to be an improvement over the usual commercial product, was one of our main activities for the year. In its preparation we received the advice and coöperation of the Retail Druggists' Association through Mr. L. A. Wikel. This kit will bear the endorsement of the Michigan State Medical Society through this Committee and will soon be on sale through retail druggists."

Your Committee requests the following information: (a) Description of the prophylactic kit. (b) In what way is this kit an improvement over others on the market? (c) By what authority can this Committee, under the name of the Michigan State Medical Society, endorse any commercial product?

This Committee does not reject the report, but merely tables action pending clarification.

Mr. Speaker, your committee recommends that the matter be tabled, and I move that it be tabled.

The Speaker: The motion is that this matter be tabled.

L. W. Day, M.D.: Be tabled and referred back to the Committee for further clarification.

C. D. Brooks, M.D. (Wayne): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Your Committee approves the report of the Tuberculosis Control Committee as written in the Handbook.

D. B. Wiley, M.D. (Macomb): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Your Committee approves the report of the Committee on Industrial Health as written in the Handbook.

I move the adoption of this report.

J. J. O'Meara, M.D. (Jackson): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Your Committee approves the report of the Child Welfare Committee with the full realization of the difficulties faced relative to the Federal pediatric aid program of recent date. It is the opinion of your Committee that the Child Welfare Committee has done excellent work on behalf of the State Society. I move the adoption of this report.

George Waters, M.D. (St. Clair): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Your Committee approves the report of the Iodized Salt Committee as written in the Handbook.

I move the adoption of this report.

C. D. Brooks, M.D. (Wayne): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Your Committee approves the report of the Committee on Heart and Degenerative Diseases as written in the Handbook.

I move the adoption of this report.

(The motion was seconded, J. J. Walch, M.D. [Delta-Schoolcraft], and carried.)

L. W. Day, M.D.: Your Committee compliments particularly the Committee on Postgraduate Medical Education for its continued and satisfactory endeavors during the past year; its work has been most commendable.

I move the adoption of this report.

R. A. Springer, M.D. (St. Joseph): I second it.

(The motion was carried.)

L. W. Day, M.D.: Your Committee disapproves the report of the Public Relations Committee as written in the Handbook, because of its laxity in recognizing the present need for more aggressive action. If ever the public should be duly informed of the pressing forensic problems of the medical profession, it is now—during the war. We recommend the new Committee be urged to special efforts in contacting the public concerning these problems during the next year.

I move the rejection of this report.

R. V. Walker, M.D. (Wayne): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Your Committee approves the report of the Ethics Committee as written in the Handbook.

I move the adoption of this report.

J. J. O'Meara (Jackson): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: There is some controversy regarding the Report of the Mental Hygiene Committee. Your Committee approves the report of the Mental Hygiene Committee as written in the Handbook.

I move the adoption of this report.

C. D. Brooks, M.D. (Wayne): I second the motion.

(The motion was carried.)

L. W. Day, M.D.: Mr. Speaker, I move the adoption of this entire report.

C. D. Brooks, M.D. (Wayne): I second the motion.

(The motion was carried.)

The Speaker: Next is the report of the Reference Committee on Special Committees, by Dr. Simpson of Wayne.

XIV-4 ON REPORTS OF SPECIAL COMMITTEES (XII, 1 to 8)

C. E. Simpson, M.D. (Wayne): Mr. Speaker, Members of the House of Delegates: The reports of six special committees were considered.

The reports of the Conference Committee on Prelicensure Medical Education, the Professional Liaison Committee and the Postgraduate Extension Committee contain no recommendations and are only reports of progress. We recommend their acceptance, as well as the reports of the Committee on Nurses Training Schools, Advisory Committee to Woman's Auxiliary, and the Beaumont Memorial Committee.

Mr. Speaker, I move the acceptance of those three reports as published:

A. F. Jennings, M.D.: I support it.

(The motion was carried.)

C. E. Simpson, M.D.: The Radio Committee presents a report of interest showing much activity. We recommend the acceptance of the report with the exception of their recommendation to abolish the Committee. It is the opinion of your Reference Committee that the interests of the State Society are better served by having an independent Radio Committee than by handing the control of broadcasting over to the University of Michigan.

Mr. Chairman, I move the adoption of the report of the Radio Committee, with the exception of their recommendation that that committee be abolished.

J. A. Kasper, M.D. (Wayne): I second the motion.

(The motion was carried.)

C. E. Simpson, M.D.: The Report of the Committee on Medical Preparedness, both the report given us last night and the report as published in the Handbook, shows a vast amount of painstaking and thankless work which has been of great importance to our state and country. We heartily approve of the Committee's Report and concur in the Committee's recommendation that its name be changed to the Procurement and Assignment Service of Physicians.

It has been known since 1940, you will recall, as the

Committee on Medical Preparedness. We were preparing then for war. In line with the nomenclature of other organizations, the Chairman of that Committee recommends that this name be changed. Your Reference Committee concurs in that recommendation.

We further recommend that this Committee be given a vote of thanks by this body for the thorough and discriminating manner in which their work is being performed.

Mr. Speaker, I move the acceptance of the report of the Medical Preparedness Committee.

E. A. OAKES, M.D. (Manistee): I second the motion.

HENRY A. LUCE, M.D. (Wayne): Mr. Speaker, as a matter of information, should that be "physicians" or "Doctors of Medicine"?

C. E. SIMPSON, M.D.: I am quoting only from the report of the committee. I will read the last paragraph of the supplementary report as given us last night by the Chairman, Dr. Urmston:

> In 1940 this Committee was called the Medical Preparedness Committee, and has been carried as the Medical Preparedness Committee for two years. Procurement and Assignment Service for Physicians is now under the War Manpower Commission, and all County Committees are so designated now. It would be less confusing if it was changed to the Procurement and Assignment Service of Physicians in the future, and I so recommended that this change be made at this meeting.

THE SPEAKER: Does that answer your question, Dr. Luce?

HENRY A. LUCE, M.D.: Not satisfactorily, Mr. Speaker.

I would move, as an amendment, that the word "physician" be deleted and "Doctor of Medicine" be inserted.

A. T. HAFFORD, M.D. (Calhoun): Second it.

P. R. URMSTON, M.D.: As only Doctors of Medicine are accepted in the armed forces, that is the designation given by your National Committee, physicians there being Doctors of Medicine.

R. V. WALKER, M.D. (Wayne): If I am not mistaken, under the recent enactment of Congress, the Navy is permitted to accept osteopaths and commission them, if the Surgeon General of the Navy approves an osteopathic school. So perhaps that might have a bearing on what Dr. Luce said, too.

THE SPEAKER: For those of you who may not have heard, Dr. Urmston makes the point that at present in the Army only Doctors of Medicine are accepted for admission. Therefore, "physicians" would mean the same thing, and in changing to "Doctors of Medicine," you would be changing the wording of the National Committee. Is that correct, Dr. Urmston?

P. R. URMSTON, M.D.: That is correct, sir.

THE SPEAKER: Dr. Walker now makes the point that by recent ruling it is possible for osteopaths to be accepted in the Navy for commission, providing their school is approved by the Surgeon General.

Do you have any further comment on that, Dr. Urmston?

P. R. URMSTON, M.D.: They don't come through this office. This heading was set up by the American Medical Association Committee, the national committee, which is composed entirely of Doctors of Medicine. I also use the words "Doctor of Medicine" in correspondence. I feel that is what is meant by the word "physician." If you just put in "Government assigned service" or "physicians"—Doctor of Medicine is all right. There won't be any mistake.

THE SPEAKER: Did I understand, Dr. Urmston, that you are willing to accept that correction?

P. R. URMSTON, M.D.: Yes, that is all right.

THE SPEAKER: Are you ready for the amendment? The amendment is that this be changed from "physician" to "Doctor of Medicine."

(The amendment was carried; the motion as amended was put to vote and carried.)

C. E. SIMPSON, M.D.: I move the acceptance and adoption of the Report of the Reference Committee on Reports of Special Committees as a whole.

WILLIAM S. GONNE, M.D. (Wayne): I second the motion.

(The motion was carried.)

THE SPEAKER: The next order of business, then, is the Report of the Reference Committee on Amendments to the Constitution and By-Laws. Dr. Hess of Bay County.

XIV-5 ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

XIV-5 (a). CONSTITUTIONAL AMENDMENTS PRESENTED IN 1942 (X, 1 to 4)

C. L. HESS, M.D.: Mr. Speaker, Members of the House of Delegates: The first four resolutions are referred over from last year. You will find them on page 20 of the Handbook. They all refer to amendments to the Constitution. Your Committee recommends the adoption of all four resolutions. I will read them individually.

1. Amend *Article III, Section 1,* as follows: "This Society shall consist of active members, honorary members, associate members, retired members, and members emeritus."

This amendment deletes the membership "junior membership."

Mr. Speaker, I move the adoption of this resolution.

A. F. JENNINGS (Wayne): I second the motion.

(The motion was carried.)

2. Amend *Article VII, Section 1,* as follows: "The Society shall hold an annual session at such time and place and of such duration as the House of Delegates and The Council may determine. This power may be delegated to The Council. Any County Society desiring the annual session shall file an application with the Council sixty days prior to an annual session."

C. L. HESS, M.D.: Mr. Speaker, I move the adoption of this resolution.

FRED DRUMMOND, M.D. (Wayne): I second the motion.

(The motion was carried.)

3. Amend *Article VII, Section 2,* as follows: "Special meetings of the Society shall be called for general session on the petition of The Council, or by a petition signed by two hundred and fifty members, or upon petition of two-thirds of the delegates seated at the previous regular session. The call" . . . etc.

C. L. HESS, M.D.: I move the adoption of this resolution.

L. W. GERSTNER, M.D. (Kalamazoo): I second the motion.

(The motion was carried.)

4. Amend *Article VII, Section 3,* as follows: "Special meetings of the House of Delegates shall be called by the Speaker on the petition signed by two-thirds of the Delegates seated at the last regular session of the House."

C. L. HESS, M.D.: I move the adoption of this resolution.

T. K. GRUBER, M.D. (Wayne): I second the motion. I would like to ask a question. Maybe I am not informed, but in that No. 2, we are changing the word "meeting" to "session." Am I correct in that?

THE SPEAKER: Dr. Hess will answer that for you.

T. K. GRUBER, M.D.: Now in No. 3—

THE SPEAKER (Interposing): Pardon me, Dr. Gruber. I don't think Dr. Hess got your question.

T. K. GRUBER, M.D.: In the comment on No. 2, it says, "change the word 'meeting' to 'session.'" That is the amendment to No. 2, isn't it?

C. L. HESS, M.D.: That is right.

T. K. GRUBER, M.D.: Now then, No. 3, "Special meetings of the Society"—does that mean special meetings or special sessions?

C. L. HESS, M.D.: There is a distinction made.

T. K. GRUBER, M.D.: I would like to know whether it is correct to say meetings or sessions there.

C. L. HESS: It is meant to be meetings.

T. K. GRUBER, M.D.: What is a meeting, and what is a session?

C. L. HESS, M.D.: An annual session usually consists of several meetings, but if there is a special meeting that would probably be one meeting of the Society. I think the word "special" could be used and it could be called a "special session."

T. K. GRUBER, M.D.: Then in No. 4 again: "Special meetings." I am wondering if we mean meetings or sessions, as we have amended above.

C. L. HESS, M.D.: At the time this was gone over, the thought was that special meetings were only one meeting, but since a session could be one meeting, I think the word "session" might be better.

T. K. GRUBER, M.D.: I don't believe you could say that a special meeting was only one meeting. We had a special meeting when we had two or three set-tos anyway, whatever they were.

THE SPEAKER: Dr. Gruber means sessions and meetings.

T. K. GRUBER, M.D.: I believe I am correct if we are going to change the title above from "meetings" to "sessions" and I, therefore, wish to amend the motion that in Article VII, Section 2, the word "meetings" after the word "special" be changed to "sessions."

Mr. Speaker, I move the reconsideration of No. 3.

THE SPEAKER: Dr. Gruber's motion is that Section 3 be reconsidered. Is there a second to that motion?

L. G. CHRISTIAN (Ingham): I second it.

(The motion was carried.)

THE SPEAKER: Now, Doctor, will you read—

T. K. GRUBER, M.D.: Mr. Speaker, Dr. Hirschman had a better amendment than I had, and I wish he would state his. He got the whole story in, and I had only part of it.

THE SPEAKER: Read the motion that is to be reconsidered.

(Dr. Hess read the proposed amendment to Article VII, Section 2, as printed.)

THE SPEAKER: Now, Dr. Hirschman, your amendment.

L. J. HIRSCHMAN, M.D. (Wayne): I move that the wording of Amendment No. 3 be changed to read as follows:

Amend Article VII, Section 2, as follows: "Special general sessions of the Society shall be called on the petition of The Council," et cetera.

THE SPEAKER: In reading, that would mean, "Special general sessions of the Society shall be called on petition," omitting the "general sessions" in the second line.

HENRY A. LUCE, M.D. (Wayne): Mr. Speaker, I think you will rule this in order. I feel we are getting confused in regard to the definition of meetings and sessions. May I call your attention to page 98 of the Handbook, in which sessions and meetings are defined. In view of that, if the last gentleman will withdraw his motion, I would move that this be returned to the Committee for a later report.

THE SPEAKER: Did you make a motion, Dr. Luce, to that effect, or suggestion?

HENRY A. LUCE, M.D.: I will make the motion, if Dr. Hirschman will withdraw his.

L. J. HIRSCHMAN, M.D. (Wayne): I will withdraw mine with the consent of the second.

THE SPEAKER: All we need is the consent of the group as a whole. All in favor of Dr. Hirschman's withdrawing signify by saying "aye"; those opposed. It is withdrawn.

HENRY A. LUCE, M.D.: I move that this be returned to the Reference Committee, with due respect and consideration for the definitions of sessions and meetings, as given on page 98 of the Handbook.

C. D. BROOKS, M.D. (Wayne): I second the motion.

C. L. HESS, M.D.: Dr. Luce, will you include both the last two resolutions, that is, Article VII, Section 2 and also Article VII, Section 3, since they both refer to that same subject?

HENRY A. LUCE: I am referring to all that have not already been approved by the House of Delegates. I think No. 1 was approved.

(The motion was put to vote and carried.)

C. L. HESS, M.D.: That completes the resolutions with reference to the Constitution.

XIV-5(b). AMENDMENTS TO BY-LAWS PRESENTED IN 1943

CHAPTER 2, SECTION 2 (IX-7)

The Committee approves the following resolution, with one change, which I will mention. I will read the resolution. This is regarding having the annual address by the retiring President at the first general session, as now provided in the By-Laws. This would have it in the third general session, which I think is better.

BE IT RESOLVED, That Chapter 2, Section 2 of the By-Laws be changed to read as follows:

"The following shall be the order of business in the general meeting at which the reports of the House of Delegates are received. This meeting shall be called Officers' Night:

"1. Call to Order
"2. Announcements and reports of House of Delegates.
"3. Retiring President's Annual Address.
"4. Induction into office of the Incoming President.
"5. Introduction of the newly elected officers."

(The word "induction into office" has been changed to "Introduction of the newly elected officers.")

"6. Special Addresses.
"7. Resolutions and motions."

Mr. Speaker, I move the adoption of this resolution.

T. K. GRUBER, M.D.: I second the motion.

Did I understand the doctor to say that they are changing the word "induction" to "introduction"? It is "introduction" in the Handbook.

C. L. HESS, M.D.: We are changing the wording in the resolution "induction into office" to "introduction."

T. K. GRUBER, M.D.: Isn't that what it is now?

C. L. HESS, M.D.: Yes, it is.

T. K. GRUBER, M.D.: It is printed in the Handbook now, on page 102.

C. L. HESS, M.D.: I will read the Section as it now appears in the Handbook.

(Dr. Hess read Section 2 of Article 2, as printed on page 102 of the Handbook.)

The proposed change includes all the officers that are elected at the last meeting of the House of Delegates; that is, not only is the new President-Elect introduced but also the Speaker, Vice Speaker, and the newly elected Council members.

THE SPEAKER: In other words, there is no change in the wording of "induction" to "introduction" but making it more inclusive.

(The motion was carried.)

XIV-5(b). CHAPTER 6, SECTION 6 (IX-5)

C. L. HESS, M.D.: Your Committee recommends that following resolution:

RESOLVED, That Chapter 6, Section 6 of the By-Laws have the name of the "Committee on Syphilis Control" changed to "Committee on Venereal Disease Control."

Mr. Speaker, I move the adoption of this resolution.

A. E. Stickley, M.D. (Ottawa): I second the motion.

(The motion was carried.)

XIV-5(b). CHAPTER 6, SECTION 9 (IX-8)

C. L. Hess, M.D.: Resolution on Chapter 6, Section 9 of the By-Laws. The resolution as presented is rather difficult to understand, and the Committee was unanimous in having it streamlined, made simple, so that all of us could understand it, including myself.

I will read the resolution as revised and recommended by the Committee.

The Committee on Ethics shall consist of five members, appointed by the President with approval of the Council, to serve for five years, so staggered that normally one member is selected annually. If a member does not serve his full term, the President may appoint a successor to fill the vacancy, who shall serve until the next meeting of the Council, which, if approved, may select him to serve the unexpired portion of the term. The rights and duties of the Committee shall be as follows:

1. To render advisory opinions on questions of ethics on the request of the Council or of a County Society.
2. To assist County Societies in setting up schemes of integration between their Ethics and Medical-Legal Committees;
3. To integrate its activities with the activities of the Medical-Legal Committee of the State Society;
4. To conduct such investigation or hearing or both, on request of a county society or of any member of this Society, as it deems appropriate, concerning the professional conduct of any member of this Society, and

To report to the county society to which the physician under inquiry belongs, its findings and conclusions for such further action as the county society may deem proper;

5. To prefer written charges in the form and manner specified by the county society's laws, with the Secretary of that society, if that society fails to institute disciplinary proceedings against a member with an adverse report, and to perform necessary acts in the prosecution of such charges;
6. To make annual report to the State Secretary.

A member who is guilty of any of the following acts shall be subject, in the discretion of the county society, to expulsion, suspension, or admonition:

1. A criminal offense involving moral turpitude;
2. Gross misconduct as a physician or citizen;
3. Violation of the Principles of Medical Ethics;
4. The wilful refusal to adhere to the Constitution and By-Laws of the Society;
5. The giving of any testimony in any court of law or administrative proceeding which is wilfully false.

Now, the object of this resolution is to clarify the rights and duties and other activities of the State Ethics Committee.

The Speaker: Dr. Hess, may I interrupt you for a moment? On that other question, you spoke of reference to the county society and so on. I haven't been able to follow this quite accurately. Is it proper for the county society to refer, the County Society Ethics Committee to refer to the State Ethics Committee without going to the State Council?

C. L. Hess, M.D.: According to the present By-Laws?

The Speaker: No, in the resolution.

C. L. Hess, M.D.: Yes.

The Speaker: In other words, a county society ethics committee may deal directly with the State Ethics Committee without going to the Council?

C. L. Hess, M.D.: Yes. I can read that particular portion.

The Speaker: I would like to say a word on that, if that is true. The State Ethics Committee and all Committees should report back to the Council.

C. L. Hess, M.D.: The present By-Law does require that the committee report its findings to the Council, but one point comes up that I think should be considered, and that is, the Council is the appellate body to which a member under expulsion or suspension may appeal.

Now the question comes up, Will the Council be prejudicial if it has reviewed a case, before the man has been tried and such expelled member might object to the Council's sitting in review on a case on which it had original action? So it purposely has been kept in mind, leaving the Council out of this picture until it is reached by appeal. That is different from the present By-Laws.

The Speaker: Gentlemen, I think that is a mistake in this way—

T. K. Gruber, M.D. (Interposing): Is there a motion before the house?

The Speaker: I don't think so. I wanted to say this for clarification. It is quite necessary that the central body of the Society know what is going on, in ethics as well as other matters. Under this, as I understand, it will be quite possible for a county society to refer a problem to the State Ethics Committee, and the Council know nothing about it.

I would entertain a motion that this resolution be referred back to the Committee for clarification.

R. H. Denham, M.D. (Kent): I wish to make that motion.

C. E. Simpson, M.D. (Wayne): I second the motion.

(The motion was carried.)

XIV-5(b). CHAPTER 8, NEW SECTION 4 (IX-1)

C. L. Hess, M.D.: The next resolution that is approved by the Committee deals with giving active members remission of dues while serving in military forces.

Amend Chapter 8 of the By-Laws by adding a new section:

Section 4. Active members shall have their annual dues remitted during the time they are on active duty in the Military Forces of the United States for periods of six months or more.

A period of less than six months would involve a remission of dues that is rather small, and besides if a military member is on the reserve military force he may be called into active duty for a period of two weeks or a month or two months, a time which we consider too short for remission of dues. So the period is six months or more.

Mr. Chairman, I move the adoption of this resolution.

William J. Stapleton (Wayne): I second the motion.

T. K. Gruber (Wayne): Mr. Speaker, I object to the six months' clause. It just so happens that in the Wayne County Medical Society we have rescinded dues. The men in the armed forces were supposed to pay their dues up until the time they left. Some of them didn't do that. We tried to get them straightened and square with the Society. Some of them took very decided umbrage at the request, and I just know that if you are going to charge people for six months' dues while they are in the Army, they are going to kick a lot, and I think rightly so. If they are going to be called to the armed forces, they should have their dues rescinded and there should be no six months about it. I think what works for one could work for the other.

I, therefore, move to amend the motion by striking out the words "six months."

C. D. Brooks, M.D. (Wayne): Mr. Chairman, I second the motion.

L. J. Hirschman, M.D. (Wayne): There is one point I think the Committee has forgotten entirely, and that is the fact that if a man is called into service he has to wind up his affairs, whether it is going to be for one week or one year or for the duration. He is really automatically disqualified from practicing medicine, even though he is sent back in two weeks. It means a disruption of his whole financial and professional setup.

I think it is perfectly right and proper, as Dr.

Gruber has said, to either omit them entirely or leave out that six months' qualification.

C. D. Brooks, M.D. (Wayne): Mr. Chairman, I intended to second the motion to have the six months deleted.

The Speaker: I am not sure Dr. Gruber made a motion.

T. K. Gruber, M.D. (Wayne): Yes.

The Speaker: There is an amendment that this part be deleted, made by Dr. Gruber and seconded by Dr. Brooks of Wayne. Are you ready for the question on the amendment?

L. W. Gerstner, M.D. (Kalamazoo): Without knowing how that would apply, that reference to physicians in the United States Armed Forces, I believe there are physicians who have entered the Canadian Armed Forces, to whom that particular motion would not apply. I wonder if it should not include all physicians, regardless of where they may have entered. I would say "any armed forces."

C. D. Brooks, M.D. (Wayne): Mr. Speaker, if Dr. Gruber is agreeable, I will second that motion to include all men fighting for their country.

Dr. Gruber has left.

The Speaker: You can't do that without Dr. Gruber very well.

Dr. Hess wanted to clarify a point in the meantime.

C. L. Hess, M.D.: I would like to ask one question. You must keep in mind that this amendment may stand even after the present World War, at which time it is presumed that many doctors will be in the reserve military forces, inactive. We don't know when they will be called into active service, perhaps two weeks a year or three months a year. Is it the wish of the Society that they get their dues remitted for the entire year if they serve two weeks when called for so-called summer drilling or for a longer period of time? This period of six months was put in to exclude that group who will serve for a short period of time each year but will not disrupt their practice.

R. J. Armstrong, M.D. (Kalamazoo): I think there is another point to be considered there. We talk about the duration, but many of these physicians are going to be tied up with this policing of the world, maybe for the duration, six months, or a year, or two years after the war. It seems it might be well to consider the time, six months after they are out, or some such figure, and give them a little chance to catch up. If we cut them off for the duration, they may still be in the armed services for a year or more.

C. L. Hess, M.D.: Mr. Speaker, may I read this again?

(Dr. Hess read the proposed amendment again.)

That is for periods of six months or more, regardless of the World War or following that. This would apply after the war as well as during the war.

C. E. Dutchess, M.D. (Wayne): Could we not vote on Dr. Gruber's motion and dispose of it, and then have the additional amendment?

The Speaker: I think this is all pertinent discussion, Dr. Dutchess, and the Speaker would like to ask a question on that now, too.

Suppose, for instance, a man is called in the National Guard, and he goes in for two weeks or a month, do we want to remit his dues?

Suppose, as Dr. Foster pointed out, there would be a riot, would that call for remission of dues?

L. J. Hirschman, M.D. (Wayne): Mr. Speaker, do you think any member of the Society would accept any such remission for two or three weeks?

Robert Baker, M.D. (Oakland): In view of the fact that our National Guard is federalized, that would apply. It doesn't make any difference what a man would take. It is what you have there. If you make it in the federal forces, when the National Guard is called into action they are federal forces, and if they go in for two weeks, Dr. Gruber's amendment would remit a year's dues.

The Speaker: In other words, you believe in the resolution as it is just stated?

Robert Baker, M.D.: Certainly. You can't simply pin an amendment on there to throw away your six months. You must have something definite. I think the Committee is right there, because our National Guard is federalized. Up to the last war, it was not, and then that would not apply. But now it does.

R. A. Springer, M.D. (St. Joseph): Would it be possible at this time to suggest, inasmuch as there already is a resolution on the floor, that this be referred back to the Reference Committee for further consideration and clarification?

The Speaker: Dr. Springer, I think it is perfectly clear. It is a question of whether they want to do it or not. There is an amendment on the floor to throw out this six months period, an amendment to the motion.

Is there further discussion on the amendment?

T. K. Gruber, M.D. (Wayne): Will the doctor make that as a motion, that it be referred back to the Committee?

R. A. Springer, M.D. (St. Joseph): I will make that motion, yes.

T. K. Gruber, M.D. (Wayne): I second the motion.

The Speaker: It is moved and seconded that this be referred to the Committee, and the motion takes precedence. All in favor say "aye"; opposed. It is carried.

XIV-5 (b). CHAPTER 9, SECTION 3 (IX-10)

C. L. Hess, M.D.: In the present Chapter 9, Section 3, it says: "Each county society shall be the judge of the qualifications of its own members; but, as such societies are the only portals to this Society and to the American Medical Association, every reputable and legal practitioner of medicine shall be eligible to membership."

Notice those words "reputable and legal practitioner of medicine."

The question comes up as to the possible interpretation of that particular wording, that type of practitioner of medicine. It is possible that rulings may be given out that such phraseology might allude to practitioners other than Doctors of Medicine, so this resolution is recommended by the Committee.

(Dr. Hess read the Dutchess Resolution re qualifications for members.)

(Dr. Hess read Article III, Section 2, of the Constitution.)

Mr. Speaker, I move the adoption of this resolution.

M. A. Darling, M.D. (Wayne): I second the motion.

(The motion was carried.)

XIII. Program of Obstetric-Pediatric Care for Servicemen's Wives

The Speaker: I have a telegram that was sent to Dr. Moyer in answer to our telegram to Dr. Dailey at Washington. Will we read it once now and, if it isn't clear, digest it afterwards?

Several Delegates: Read it.

Washington, D. C. 11/21/10.18A.
H. Allen Moyer, M.D.
Care Statler Hotel Det—
Telegram received from P. L. Ledwidge, M.D., Speaker of the House of Delegates Michigan State Medical Society Quote Pursuant with telephone conversation of this morning please

wire collect not later than eleven a.m. September 21st legal opinion on this point naming authority giving opinion. Is it possible for the wife or infant of an enlisted man treated as a private patient on a fee basis to receive hospital benefits under the Obstetric-Pediatric programme in other words may a patient take advantage of the hospital phase without the medical a favorable decision on this point would lessen our problem in Michigan very materially unquote have wired him I am forwarding information to you it is as follows:—

The Labor Department—Federal Security Appropriation Act for the current fiscal year appropriates grants to states to provide medical, nursing and hospital maternity and infant care for wives and infants of enlisted men in the armed forces of the United States the act provides that grants shall be made to carry out plans developed and administered by State Health Agencies and approved by the chief of the Children's Bureau thus the act vests in the chief of the Children's Bureau the responsibility for determining whether a state plan will carry out the purposes of the act. The Secretary of Labor has issued a regulation that the state plans shall meet the requirements of Section 503 (A) Subsections 2, 3, 4 and 6 of the Social Security Act. Congress made appropriations for the emergency maternity and infant care program in order to assure enlisted men's wives complete maternity care and care of infants and to relieve enlisted men and their wives of any financial anxiety in obtaining such care. Nearly 90 per cent of enlisted men whose wives and infants are eligible for care are in four lowest pay grades with top pay $78 a month. As recommended by Congress wives of enlisted men in three highest grades will have care authorized quote when circumstances require unquote. The *Chief* of the Children's *Bureau* has *determined that* the purpose of the Act can not be realized if the wives requesting care under the program are required or permitted to pay directly to private physicians or hospitals for the medical or hospital care needed. Accordingly, she has not approved emergency maternity and infant care plans which required or permitted persons requesting care under the plan to pay private physicians or hospitals for care authorized by the act for the reasons that under such plans *individual negotiation as to costs would* be required and it would be impossible to assure wives the complete care at the level of costs provided under the plan. *The above determination* of the Chief of the Children's Bureau *is not* of course *intended to prevent patients from defraying* if they wish *a portion of the cost* of the medical nursing and hospital care provided them *since a state Health Agency may accept* from a patient *any portion of the total cost (Paid by the Agency) which the patient wishes to pay.*

MARTHA M. ELIOT, M.D.

THE SPEAKER: In other words, if I interpret that correctly, a patient who wishes to, may pay part of his expense, or her expense, but she would have to pay it into the State Department of Health, and they in turn would distribute it to the medical men.

SEVERAL DELEGATES: It doesn't say that.

THE SPEAKER: Yes, it does, it implies that. I will tell you why it implies it, because it says, "the medical, nursing and hospital care." They certainly cannot pay the medical care to someone who doesn't do it. So if the patient accepts this program or takes advantage of it, and wishes to pay part of that expense, as I understand it, she can pay it into the State Department of Health, and then the State Department of Health will use its own judgment about paying the hospital or the doctor.

C. E. DUTCHESS, M.D. (Wayne): I think the proper interpretation of that is the payment might be made within the amount of money that is payable by the Federal Government for this service. In other words, $40 is paid to the physician. If the woman or family wishes to pay toward that expense, it would be paid within that $40, not above it.

THE SPEAKER: That is right, and paid through the state.

C. E. DUTCHESS, M.D.: The state would only accept it then as a credit to the program.

That is the principle followed in a great many similar situations in connection with funds.

THE SPEAKER: Did you all hear Dr. Dutchess' point? This money, if a patient wishes to stand part of the expense, would still be within the limitations of the charge that is made to these people, which is now paid by the Federal Government through the state, but they would remit that through the state fund, and it would simply be added to the general fund for this program. That is your point, isn't it?

C. E. DUTCHESS, M.D.: Yes.

THE SPEAKER: Well, will we hand this over to the Resolutions Committee, who has our resolutions on the Obstetrics and Pediatric Program? Will that meet with the approval of the group?

WILLIAM J. STAPLETON, M.D. (Wayne): I so move.

(The motion was seconded and carried.)

THE SPEAKER: In the envelope with this, which I didn't notice at first, there is a ruling given out in July. May I have the privilege of referring that to them also, or do you want that read now?

DELEGATES: Yes.

THE SPEAKER: It says: "Supplement to be attached to M.C.H. for circular No. 13." That is dated July 20, 1943, from the Commission of the United States Department of Labor Children's Bureau to the Michigan Health Department here. It covers the same thing.

Request for authorization of hospital care only should not be approved unless medical care is also authorized by the state agency, or unless the state agency has been advised that medical care, after the authorization of hospital care was requested, will be provided without cost to the patient.

It is the same thing. It simply shows what we are up against. It is only five days since I talked to Dr. Dailey, who was one of the big-wigs in the Children's Bureau. In fact, he told me confidentially that he was one of the three who would have any authority. He said, "No ruling has been made on that point," and yet here is a ruling that they sent to our Michigan Department of Health on July 20. That is the same old run-around.

This will be referred to the Resolutions Committee.

If it is agreeable, we will entertain a motion to recess. Remember that Michigan Medical Service meets at two o'clock and that our next meeting is at eight tonight.

(The meeting recessed at twelve fifty-five o'clock.)

Tuesday Evening Session
September 21, 1943

The meeting was called to order at eight thirty-five o'clock, P. L. Ledwidge, M.D., the Speaker, presiding.

THE SPEAKER: The House will please come to order. Is the Credentials Chairman ready to report?

J. J. O'MEARA, M.D. (Jackson):

I have in my hand the credentials of eighty-four members, 40 per cent of which are not from any one county.

THE SPEAKER: If there is no objection, we will accept this report as the roll call, and declare the session now in order.

Is there any unfinished business to be presented?

Is there a supplementary report on the Council?

A. S. BRUNK, M.D.: No.

THE SPEAKER: We will then turn to the reports of the Reference Committees. Is there any supplementary report from the Reference Committee on Standing Committees?

L. W. DAY, M.D.: Mr. Speaker, there is no supplementary report.

THE SPEAKER: From the Reference Committee on Special Committees?

C. E. SIMPSON, M.D. (Wayne): There is no further report.

THE SPEAKER: Any special report from the Reference Committee on Constitution and By-Laws?

XIV-5(a). ARTICLE VII, Section 2 (X-3)

C. L. HESS, M.D.: The Reference Committee on Amendments to the Constitution and By-Laws has approved the following, with reference to the amendment to the Constitution.

The first has to do with the discussion of the difference between meeting and session.

It now reads as follows:

Special sessions of the Society shall be called on the petition of The Council, or by a petition signed by two hundred and fifty members or upon petition of two-thirds of the delegates seated at the previous annual session.

The word "meetings" has been changed to "sessions" and "the delegates seated at the previous annual session."

Mr. Speaker, I move the adoption of this resolution as revised.

C. F. BRUNK, M.D. (Wayne): I second the motion.

(The motion was carried.)

XIV-5(a). ARTICLE VII, SECTION 3 (X-4)

C. L. HESS, M.D.: In the second amendment to the Constitution, the same question came up. The revised amendment reads as follows:

Article 7, Section 3:
Special sessions of the House of Delegates shall be called by the Speaker on the petition signed by two-thirds of the Delegates seated at the last annual session of the House.

Mr. Speaker, I move the adoption of this resolution.

E. R. WITWER, M.D. (Wayne): I second the motion.

(The motion was carried.)

XIV-5(b). CHAPTER 8, NEW SECTION 4 (X-1)

C. L. HESS, M.D.: The amendment referring to remission of dues of acting members in active military service was carefully studied, and a change made in the period of time when they should be in active service before dues may be remitted.

The amendment reads as follows:

Chapter 8, Section 4:
Active members shall have their state dues remitted for the period, calculated to the nearest quarter, that they are on active duty in the Military Forces of the United States or its Allies.

That is a new addition here, a new revision of the "Military Forces of the United States or its Allies." It is possible that some United States doctor, who is an active member of our Society, may be serving in the armed forces of the Allies and still retain his citizenship in this country, and so in case that should occur, this provision will take care of that continuously.

Now, it is believed that the important thing is the remission of dues of such members. Whether those remissions shall be for one period or a shorter period I think is of lesser importance. Yet, I think it should be specified, because it was the intent of the maker of this resolution not to include those who are members, we will say, on the reserve military forces, but called into active training two weeks a year, more or less. Some time interval should be set so as to not have those members have their dues remitted, say, for the next ten, fifteen or twenty years.

"Calculated to the nearest quarter" may sound a little technical, and the Chairman of the Reference Committee will yield the floor to Dr. Gruber to explain that, if he so wishes.

Mr. Chairman, I move the adoption of this resolution.

T. K. GRUBER, M.D.: I second the motion.

S. L. LOUPEE, M.D. (Cass): Suppose that under this resolution, in the event that activities should cease in this war, that peace should be declared, but our Government should maintain a standing army abroad, would that also include these men who are serving at that time?

C. L. HESS, M.D.: Yes, so long as the man is on active duty.

THE SPEAKER: Further discussion?

R. H. DENHAM, M.D. (Kent): Can't that be so worded that we may remit dues for a whole year when men serve during an emergency? If they serve during peacetime for a month or two months, that may not be referred to, but when they serve during an emergency, can't we remit a year's dues? I think it is kind of strange that we would shut them down to a quarter of a year. I don't believe it would harm us to remit dues for a year if they have occasion to serve not more than six months in an emergency. Certainly their practice is going to be so disrupted that they will suffer a great deal more than we will suffer by remitting the year's dues.

I would like to offer that as an amendment to your amendment.

THE SPEAKER: Do you make that as a motion?

R. H. DENHAM, M.D.: As a motion. I move that we change that to read that so long as a man serves during an emergency, a year's dues be remitted.

T. K. GRUBER, M.D.: I second the motion.

THE SPEAKER: If I understood you correctly, it is that this be changed from six months to one year. Is that your intention, Dr. Denham?

D. H. DENHAM, M.D.: It doesn't matter whether he is serving one month or two months or three months, if it is in an emergency. It is going to cost him a lot more to give up a month or two months for an emergency than it is going to cost this Society to remit a year's dues.

THE SPEAKER: You mean the dues will be remitted for one year instead of six months?

HARRY F. DIBBLE, M.D. (Wayne): Suppose it is just one day, it is still an emergency.

T. K. GRUBER, M.D. That is all right.

HARRY F. DIBBLE, M.D.: You are getting awfully liberal.

T. K. GRUBER, M.D.: Mr. Speaker, a man can get shot in one day just as well as he can in ten years.

HARRY F. DIBBLE, M.D.: He won't need any dues then, if he is shot."

THE SPEAKER: Are you ready for the question on the amendment, that this be changed to one year instead of six months?

A. F. JENNINGS, M.D. (Wayne): I thought we eliminated the six months clause.

THE SPEAKER: It is one year to the nearest quarter.

A. F. JENNINGS, M.D.: There is no "one year" in it.

D. H. DENHAM, M.D.: The amendment is, if I may explain it, that he be forgiven a year's dues if he serves during an emergency during that year. If he serves in an emergency during that year, he will be forgiven a year's dues.

THE SPEAKER: Instead of having his dues cancelled to the nearest quarter.

D. H. DENHAM, M.D.: Yes.

A. F. JENNINGS, M.D.: I think we still have to run the Society, Mr. Chairman. We have to have money to do it.

THE SPEAKER: Is there further discussion on this amendment?

C. F. BRUNK, M.D. (Wayne): After all, we have organized this Society for the protection of these boys who are away, as to their interest. I don't feel that there is any necessity of forgiving dues for any extended period.

THE SPEAKER: Is there further discussion on this point?

If not, are you ready for the question?

(Calls for the question.)

It would then be amended to read: "Active members shall have their state dues remitted for a period of one year, in case of emergency service in any part of the year."

All those in favor of this motion say "aye"; all those who say "no," please rise. Now all those in favor of the amendment, which should have been

voted first—I am sorry— those who are in favor of remitting one year's dues, please rise.

R. A. SPRINGER, M.D. (St. Joseph): I don't think the proposition is understood.

THE SPEAKER: There are thirty-eight voting for cancelling the dues for one year, and thirty against cancelling the dues for one year. Before the chair announced the vote, one man said he thought it was not clear. How many do not understand the amendment? Will I state it once more?

It is the intent that any member who serves during an emergency for any period of time whatsoever shall have his dues remitted for one year.

L. G. CHRISTIAN, M.D. (Ingham): Suppose he serves three years

THE SPEAKER: He only pays one year at a time.

HAROLD ROEHM, M.D. (Oakland): What do you mean by an emergency? Is this war an emergency, or is it a race riot?

THE SPEAKER: An emergency.

Do you want another vote on this question? I will put the question once more. In the case of a national emergency, that is what it is intended to be, any member serving for any period of time shall have his dues remitted for one year.

R. V. WALKER, M.D. (Wayne): Do you specify that as a national emergency? That makes a lot of difference. A national emergency one week, that is one thing; a race riot here in Detroit for two weeks is a different thing. I think that ought to be specified, whether it is a national emergency or just any emergency. It is two different things.

A. F. JENNINGS, M.D. (Wayne): Well, after all, this is an amendment to help the men who enter military service. It seems to me we are going rather far afield. We are talking about any emergency. I think the amendment is perfectly satisfactory as it stands.

A. F. JENNINGS, M.D.: I said "amendment." I meant the amendment to the original Constitution as it stands.

THE SPEAKER: That is not what we are doing. We are talking on the other amendment.

Dr. Denham, will you please state, as clearly as you can, what you mean by your amendment or reword your amendment, if you wish?

D. H. DENHAM, M.D. (Kent): My idea is that when we have a national emergency a man gives up his practice to serve in the armed forces, and even if he serves only a month or two, I feel that he should have at least a year's dues remitted, because of the hardship it works upon him, in giving up his practice. It is certainly a greater loss to him than it would be to us to remit a year's dues. That is the thing I intended, in a national emergency or a war emergency.

THE SPEAKER: May I ask one question on that for clarification? When you speak of remitting one year's dues, you mean remitting what he has paid in, or do you mean giving him one year's free membership, or both?

D. H. DENHAM, M.D.: I would at least give him one year's dues for his service. If he serves three years, he would get three years' dues. If he serves two months of one year, he would get one year's dues.

T. K. GRUBER, M.D. Wayne): Mr. Speaker, I don't think any of the men here have served in Guadalcanal or North Africa or in Sicily or in Italy. I don't think any of you have. I don't think you have been away from your practice for a year or a month. I am not practicing medicine, you understand that. You are away from your practice, and you have lost an awful lot. I believe that these boys who go voluntarily, as most of them have, should have some consideration. I believe the amendment to the nearest year is no more than fair and right and the best thing we can do for these men.

A lot of men here went to the last war. They took their chances, and they came back, and they had a hard time making things go when they came back. We stand up here and argue as to whether a man should have a month or six months or a quarter or a year. For goodness sakes, what are these men sacrificing that are going away? I believe that one year to the nearest year is the proper thing to do.

R. A. SPRINGER, M.D. (St. Joseph): Won't it clarify the whole situation if we substitute "a war emergency" instead of "national emergency?"

SEVERAL DELEGATES: No.

R. A. SPRINGER, M.D.: I think some of the objections that some of these men, after they get back in peacetime might have a year's dues remitted for training at Fort Custer for a week or two perhaps—I think that is what they are worrying about.

HENRY A. LUCE, M.D. (Wayne): I am pleased to introduce to you, Commander Ellet of Benton Harbor, who would like to talk on this subject.

THE SPEAKER: Commander Ellet is one of our old members and highly respected. Would you like to come up here, Doctor?

COMMANDER ELLET, U.S.N.: Mr. Speaker, don't argue about it. We are not asking for anything. The men who are in the service don't ask for it. If you want to give them their dues, that is swell, whether it is for a day or a month. My county society has given it to me now for three years. But for God's sake, don't argue about it. Either do it, or don't.

DELEGATES: Right!

THE SPEAKER: Thank you.

ROBERT BREAKEY, M.D. (Ingham): Mr. Chairman, I don't believe it is a matter of arguing anything. It is a matter of understanding this. We have had so many amendments and so many different statements made that nobody knows where we are. That is the great trouble. You have made so many amendments you don't know what you made yourself.

THE SPEAKER: All right. We are ready for the question. All those in favor of the amendment, which would remit one year's dues for men who are in the armed service, emergency service, national emergency, for any purpose, say "aye"; opposed. It is carried.

A. F. JENNINGS, M.D. (Wayne): Point of order! The original motion has not been passed.

THE SPEAKER: Passed as amended. That really wasn't an amendment to the motion. It was really a resolution amended. It should have been stated, passed as amended. Thank you, Doctor.

XIV-5(b). CHAPTER 6, SECTION 9 (IX-8)

C. L. HESS, M.D.: The next resolution concerns the Committee on Ethics. The Committee studied this at considerable length and in the discussion several new points came up on which there was no clear answer. The five chapters dealing with ethics were rather confusing and complicated, so it is the consensus of the committee that this be referred back to the special committee for study of this subject.

Mr. Speaker, I make that motion.

C. D. BROOKS, M.D. (Wayne): I second the motion.

(The motion was carried.)

C. L. HESS, M.D.: Mr. Speaker, I move the adoption of the report as a whole as amended.

WILLIAM J. STAPLETON, M.D. (Wayne): I second the motion.

(The motion was carried.)

THE SPEAKER: The next order of business, gentlemen, is the Report of the Resolutions Committee.

XIV-6. ON RESOLUTIONS RE SPECIAL MEMBERSHIPS (VIII-8)

S. W. INSLEY, M.D. (Wayne): I am ready to report for the Reference Committee on Resolutions.

First, we have to do with the resolution of Dr. Haf-

ford in regard to making Dr. Starr K. Church of Calhoun County a member emeritus. The Reference Committee recommends the adoption of the above resolution of Dr. Church for member emeritus.

I so move, Mr. Chairman.

C. S. GORSLINE, M.D. (Calhoun): I second the motion.

(The motion was carried.)

S. W. INSLEY, M.D.: The next resolution has to do with a membership emeritus for Dr. Joseph M. Croman, Sr., of Mt. Clemens.

The Committee recommends the adoption of the above resolution.

Mr. Chairman, I so move.

E. R. WITWER, M.D. (Wayne): I second the motion.

(The motion was carried.)

S. W. INSLEY, M.D.: The next resolution has to do with two physicians in Wayne County.

The Reference Committee on Resolutions has approved the resolution as submitted, subject, however, to final ratification through the Executive Office. We understand it has been cleared and the records are not entirely clear as of this date. Your Committee recommends the adoption of this resolution, subject to clearance through the Executive Office at Lansing.

I so move, Mr. Chairman.

C. F. BRUNK, M.D. (Wayne): I second the motion.

(The motion was carried.)

XIV-6. DECLARATION OF MEDICAL POLICIES (VIII-6)

S. W. INSLEY, M.D.: The next resolution, by Dr. McClellan of Wayne County, in relation to the declaration of medical policies.

The Reference Committee adopted this resolution unanimously.

Mr. Chairman, I so move, the adoption of this resolution.

C. E. SIMPSON, M.D. (Wayne): I second the motion.

(The motion was carried.)

XIV-6. CAMPAIGN FOR PUBLIC INFORMATION ON MEDICAL CARE BY AN ASSESSMENT (VIII-11)

S. W. INSLEY, M.D.: The next resolution introduced by Dr. McClellan has to do with a campaign for public information on medical care.

Your Committee was in accord with a great deal of the thought in this resolution and simply reworded it as follows:

WHEREAS, It appears that the public has not been sufficiently informed as to the deterioration in medical service which will result if certain movements should materialize to change the system of medical care, therefore be it

RESOLVED, That the membership of the Michigan State Medical Society be assessed $10.00 per capita for public educational purposes during this present year, and be it further

RESOLVED, That these moneys be disbursed under the general direction of the Council of the Michigan State Medical Society.

The Reference Committee unanimously adopted this modification and, Mr. Chairman, I so move.

T. K. GRUBER, M.D. (Wayne): I second the motion.

(The motion was carried.)

XIV-6. EDUCATIONAL FUND (VIII-1)

S. W. INSLEY, M.D.: The next resolution has to do with the one brought up by Dr. Springer, concerning aid which might be given to the children of doctors, when the doctors die without sufficient estates.

I will read the original resolution—I think we have all heard that last night. It is in the record. I will read the resolution as modified by the Resolutions Committee. In re the resolution of Dr. Springer:

The Reference Committee unanimously approves of the sense of this resolution, believing that such an arrangement is admirable and further believing that such a program is not inconsistent with the constitution of the State Society.

The Committee, therefore, recommends:

1. That the Council be authorized to establish a Medical Scholarship Fund available to siblings of members of the Michigan State Medical Society for Medical Education.
2. That such funds shall be considered as a Medical Scholarship fund and held separate from other Society funds.
3. That management of such fund be under the direction of the Finance Committee.
4. That applications for loans shall be accompanied by recommendations of the local County Medical Society.
5. That all loans to applicants bear standard rates of interest.

The Reference Committee unanimously agreed on this matter, and, Mr. Chairman, I so move its adoption.

ROBERT L. WADE, M.D. (Branch): I second it.

THE SPEAKER: The motion is made and seconded that the resolution be adopted. Those in favor of the motion signify by saying "aye"; those opposed. Will those who vote "no" please stand? The motion is carried.

HENRY COOK, M.D. (Genesee): I rise to a point of order. No opportunity for discussion was given on that motion. I have no objection to the principle of it, but I would like to point out one possibility whereby I think it may not work.

THE SPEAKER: I believe Dr. Cook is right, and I apologize to Dr. Witwer.

T. K. GRUBER, M.D. (Wayne): Mr. Speaker, I move that the motion be reconsidered, so these people can have a chance to argue.

THE SPEAKER: Just a motion. The motion to reconsider is now upon the floor. All in favor say "aye" —carried—and with it will go my apologies to Dr. Witwer, Dr. Cook, and all the rest of the gentlemen who wish to discuss it. Now, Dr. Witwer, you have the floor.

E. R. WITWER, M.D. (Wayne): Mr. Speaker, I wish to know where these funds are coming from. There is nothing specific stated in the resolution as to what the source of this resolution shall be. If I may be permitted to review the report which my committee gave on this very problem, I should like to state that we feel that entering into a project of this type is actually underwriting somebody on an insurance basis. Are we legally authorized to do that as a state medical society? Whether you are loaning it out to them on an interest basis or note, are we authorized from the legal standpoint to do something of that kind, and where is the money coming from?

HENRY COOK, M.D. (Genesee): I have had some little bit of experience with endowments on scholarship funds. I see a danger in the method of administration which this committee has recommended. I happen to know that the Finance Committee of the Michigan State Medical Society changes nearly every year, at least to a degree, and funds such as this are more or less perpetual, and it would seem to me that if those funds are set aside it should be in the hands of more or less a permanent committee which has a permanent policy for the protection of the funds. That is simply an opinion I would like to recommend for your consideration.

ROBERT BREAKEY, M.D. (Ingham): The Chairman did not read the original motion which the committee merely amended by the five points. In other words, the motion has been read twice before the house, and specified, Dr. Witwer, that the funds would be raised by contributions, would be a dollar per member, not by

assessments, and that the St. Joseph Society had started the establishment of funds by the donation of $100.

This does not come out of the general funds. It is not an assessment, but is a donation or contribution of one dollar per member. That was in the original motion which the Chairman didn't read, to save time. That was presented to the House yesterday.

Concerning Dr. Cook's comment, the committee certainly considered that. I agree with Dr. Cook, that if the Finance Committee of the Council is a readily changing organization and a fund of such perpetuity as this one proposes to be is to be managed by such a committee, that it might well be better to appoint or elect a more permanent rotating committee, so that the supervision of the management of these funds might be in continuity instead of interrupted.

THE SPEAKER: Before we have further discussion, I think it is only fair—this is an important thing, establishing a fund of this time—for Dr. Insley to read the original resolution.

(Dr. Insley read the original resolution.)

S. W. INSLEY, M.D. (Wayne): Now, may I add just one word on this point? I think it would be the sense of the committee—we mentioned the Finance Committee as being the body to handle these funds. I think Dr. Cook's observation on this matter is quite correct. As far as the committee is concerned, it can be handled by the Council or any other continuous revolving body which might have the policy follow through in the same manner from year to year.

THE SPEAKER: May I say one word in clarification? If I understand this correctly, it is to be done by contribution of each member of one dollar per year. Nothing is said about how this contribution is to be made. Do I properly assume this is to be collected in the state on society dues per year. Dr. Springer, it is your motion.

R. A. SPRINGER, M.D. (St. Joseph): That is my intention, yes.

THE SPEAKER: In other words, the Society dues of the members would be raised one dollar per year. Is that correct?

ROBERT BREAKEY, M.D. (Ingham): Mr. Chairman, it was not the committee's understanding. It was clearly understood and worded as a contribution and not an assessment, Mr. Chairman. It was our understanding, and it was discussed at some length—I am not taking the chairman's prerogative, I hope—That this was to be paid through the Secretary's office as a contribution and not as an assessment, and it could be paid at any time. It can be paid at the time of payment of dues, but the resolution does not say it is an assessment; it is a contribution.

THE SPEAKER: Then, if I understand you correctly, Mr. Breakey, there would be no regular way of collecting this or of enforcing its collection. It would be a contribution by such members as sought to make it. Is that correct?

ROBERT BREAKEY, M.D.: I was in favor of this before the committee, and the committee unanimously endorsed it. Since it is operating in Ingham County, it has been employed to most beneficial circumstances in the past seven years. In other words, it is not without precedent within medicine. In such cases as Dr. Springer mentioned, in the death of four of our members, four of their children who were unable otherwise to obtain an education obtained it, such as this, in the Ingham County Medical Society, and it has inevitably been repaid with interest.

We have not changed, except in very few additional recommendations, Dr. Springer's resolution. The wording of Dr. Springer's resolution is "contribution." I would rather have Dr. Springer explain it, but it was distinctly not an assessment, and I believe, Mr. Chairman, the committee understood it was not to be an assessment. Is that not right?

THE SPEAKER: That is very nice, but I think before that motion passes there should be an understanding of how this money is to be collected, because the fact that Ingham County members saw fit to contribute to their own local members is probably not entirely an indication that another county society might want to contribute to them. You should put in some method by which the money is going to be collected if you really want it to operate. That is only a personal opinion, but I believe it is practical.

ROBERT BREAKEY, M.D.: Then for the sake of clarification of the issue—and one dollar is so small for such a worthy purpose—I move an amendment to Dr. Springer's motion, that an additional assessment be made for one year of one dollar per active member, to establish such a fund, and that such additional assessments may be made as may meet with the approval of the House in ensuing years.

THE SPEAKER: May I ask Dr. Breakey one other question? Do you wish this to apply to all members, or to only the active members who are now paying dues? You see, there are a good many of the military.

ROBERT BREAKEY, M.D.: I stated "active."

THE SPEAKER: Paying members.

ROBERT BREAKEY, M.D.: Active paying members.

THE SPEAKER: Then the amendment is that an assessment of one dollar per year for one year be made on all active members to start this fund or to contribute to it. Is there a second to that?

DON V. HARGRAVE, M.D. (Eaton): I second the motion.

ERNEST N. D'ALCORN, M.D. (Muskegon): I am going to go back to Muskegon, and they will ask, "Why all the special assessments?" This year we have $10 for publicity, and now we have another dollar of assessment. I would rather donate it, because some of them are going to wonder where it is coming from, adding all the special assessments all at once. We haven't had special assessments before, and all at one we have so many.

A. E. STICKLEY, M.D. (Ottawa): I think you are getting in deep water. One member said to me, "Look what the unions pay; we ought to be able to pay as much as they do."

I feel the same as this doctor does. I am going back to my county, and they are going to ask, "Why the assessment of $10?" In our county at present we pay $20 dues, and with the $10 and this $1, it will be $31.

We don't all think alike. Maybe you people here in the eastern part of the state have more money floating around. You can catch the "eagles" quicker. But I think we had better go slowly. I don't think we should consider those things.

F. G. BUESSER, M.D. (Wayne): Mr. Speaker, I think, as the preceding speaker has expressed himself, we are getting into trouble. I think one should recognize this fact. The good supervisor who was here yesterday talked about local government.

It is the policy of Ingham County to make voluntary contributions toward the education of a sibling of a doctor in Ingham County. I think that is quite a county affair and well within its rights.

I would also like to call attention to this fact, that in Wayne University, in the City of Detroit, and at the University of Michigan in Ann Arbor, loan funds are available. I might add, for the benefit of you men who do not realize it, that the Woman's Auxiliary of the State Medical Society has had some extra funds which from time to time it has loaned to individuals, sometimes at the prescribed rate of interest and other times without interest. In other words, that thing has been done in Wayne County usually for students who are residents of Wayne County. I think it may be well within the rights of the individuals of this or-

ganization to make a voluntary contribution to a certain fund which might be administered by properly appointed officers, but I do think that the gentleman from Ingham County have a definite obligation to the siblings of doctors in Ingham County. I think we should not make this a state affair. I think that it should be a county affair subsidized by the individual counties rather than by the State Medical Society as an institution.

ROBERT BREAKEY, M.D. (Ingham): Mr. Speaker, with the permission of my second, I will withdraw the motion on the assessment. It wasn't the sense. The Chair asked for information as to how it would be collected. That was not the committee's idea, and with the further comment.....

THE SPEAKER (interposing): You can't further comment on that now. If you wish to withdraw your motion, all you need is the consent of the body. Dr. Breakey asks permission to withdraw his motion. Is that agreeable?

DELEGATES: Yes.

ROBERT BREAKEY, M.D.: Then, Mr. Speaker, with further reference to Dr. Buesser's comment, the individual county, that was brought up before the committee. In Ingham County, Bay County, Wayne County and Kent County, the point you make is excellently well put, but in Oscoda County it isn't, and they are members of the State Medical Society, and in some of the Upper Peninsula Counties, and in the five-county society they have very few physicians and their income rate has been low throughout the state.

I think the sponsor of this motion—I am pleading his cause—voices a truly worthy sentiment in paying for the children of our physicians to be educated, regardless of the county boundaries. Some of our county societies are wealthy and some of them are truly destitute. I don't know whether this Society knows that in Lake County, Michigan there is not one doctor resident.

F. G. BUESSER, M.D.: The boys in Michigan and the girls have a chance to go to either the University of Michigan or Wayne Unversity, and both those universities have endowment funds already available and are lending money to those who need it and who are deserving. I feel that those who want to make donations haven't done so. Some of us have done so for quite a few years. Those who wish to have put it into funds already established, because the boys or girls who go to school in Michigan are going to the two schools where the endowment is already established. All they need is more endowments.

L. J. BAILEY, M.D. (Wayne): I think the resolution is a good one, and deserves adoption, but a great deal has been made at these meetings about the definitions of words. Am I misinformed? I think "sibling" is a brother or sister.

S. W. INSLEY, M.D. (Wayne): Dr. Breakey, would you explain the wording?

ROBERT BREAKEY, M.D.: I may be mistaken on that, but my interpretation of "sibling" is that it is an offspring. A sibling is not only a son and not only a daughter. Siblings are offsprings of two parents.

T. K. GRUBER, M.D. (Wayne): I would like to enlighten Dr. Breakey, being a psychiatrist, "sibling" being a psychiatric word, and Dr. Breakey being out of place in using it—sibling is a brother or sister.

R. A. SPRINGER, M.D. (St. Joseph): Mr. Speaker, this was my resolution. I thank you, Doctor, for carrying on for me. I had in mind one particular instance when I formulated this resolution, and I am sure that if anyone here would think of a similar illustration, in addition to all these splendid arguments I offered for the resolution last night, you would need no other than this humanitarian viewpoint.

I know a doctor's son, and this doctor was one of the finest practitioners of medicine in the state of Michigan, that the state of Michigan ever had. He had the ideals which we hold so dear in our hearts as far as organized medicine is concerned. He has two sons. One will graduate next year and one this year, and they are following in their father's footsteps and are going to be practitioners of medicine of whom we shall be very, very proud.

Now these two boys, in spite of the endowments mentioned, would not have been able to carry on their medical education if it had not been for the altruistic aims of a friend of the family. I do not believe that the endowment funds are available to pre-medical students, and surely to become a medical student you have to become a pre-medical student first. I may be wrong about that.

It is unfortunate that my resolution was presented at a time when an assessment of $10 was before you, but it seems to me that a dollar a year is a mighty small sum to produce a doctor of medicine of whom we can be proud.

THE SPEAKER: The Chair recognizes Dr. Corbus, our Past President.

B. R. CORBUS, M.D.: I am interested in some plan to permit some young man who would not be able otherwise to study medicine to do so. I think it is a worthy thing that you have undertaken here. I am particularly interested because I have a son who may want to study medicine and I may want to have him helped. But it seems to me, in the first place, it should be a voluntary contribution, and in the second place, it seems it ought to be worked out a little better than it has been worked out so far as the handling of the fund is concerned.

I am sympathetic with Dr. Henry Cook's statement that in the moving of the Finance Committee we would run into some difficulties. We ought to have a permanent committee to handle this thing. It doesn't seem to me that it was thoroughly studied.

I have a feeling that this is not constitutional, as an activity of the state, except as you have a committee working with this society, not as a part of the assessment of dues and the handling of moneys which come into this society. I may be wrong, but it seems to me this has been up before when I was President and Chairman of the Council, and we found we could not do it.

Would it be possible to throw this back into the committee for further study to see how it can be handled in a practical and legal way?

E. R. WITWER, M.D. (Wayne): Mr. Chairman, I move that the matter be tabled.

D. C. BEAVER, M.D. (Wayne): I second the motion.

THE SPEAKER: The motion is made and seconded that the matter be tabled. All in favor say "aye"; opposed. We will have to have a rising vote. All in favor please rise, and remain standing until you are counted. Those against tabling the motion please stand. There are fifty-four in favor of tabling and thirty-four against tabling. The motion is carried.

XIV-6. HOSPITAL LICENSING ACT (VIII-12)

S. W. INSLEY, M.D. (Wayne): The next resolution was by Dr. Christian concerning a Hospital Licensing Act.

Your Reference Committee feels that the resolution covers a lot of ground, in a rather vague way, and made the following recommendation:

"We recommend that the Legislative Committee be instructed to explore the project, and to approve or disapprove such specific legislation as may be introduced."

That recommendation was unanimously adopted by the committee.

Mr. Chairman, I move its adoption here.

C. D. Brooks, M.D. (Wayne): I second the motion.

(The motion was carried.)

XIV-6. TO IMPROVE PUBLIC RELATIONS (VIII-7)

XIV-6. AMA BUREAU OF INFORMATION (VIII-13)

S. W. Insley, M.D.: We next considered a resolution by Dr. Luce to "Improve Public Relations." There was also a resolution introduced by Dr. Christian which covered about the same round. The Committee felt that both of these resolutions should be read and spread on the record, and then we shall offer the recommendations of the committee.

Gentlemen, these two resolutions rather dovetail. The Reference Committee felt that it might be summed up as follows:

Resolved, That the House of Delegates of the Michigan State Medical Society instruct its delegates to the American Medical Association House of Delegates to support and fight for the principles enunciated by the several states in resolutions which were aimed to establish in Washington, D.C. a bureau of information to aid members of Congress, in order to defeat attempts to lower the standards of the practice of medicine in the United States; and be it further

Resolved, That the Executive Committee of the Michigan State Medical Society be instructed to contact all other State Medical Societies for the purpose of implementing this objective.

The Reference Committee feels that these last two resolutions, as I have just read them, should be carried, and, Mr. Chairman, I move the adoption.

Harry F. Dibble, M.D. (Wayne): I second the motion.

Clarence E. Toshach, M.D. (Saginaw): I understand the next meeting of the American Medical Association is next June. By the time that comes around, all the bills we object to will be passed. It seems to me we should activate this thing a little bit more rapidly than that.

The Speaker: Does the Chairman wish to comment on Dr. Toshach's point?

S. W. Insley, M.D.: That point was brought up in the committee, and we felt, which I think was also included in the original resolutions, that by contacting all other state societies for the purpose of implementing this objective, if the other state societies feel the way we do, we might not have to wait the full year. I think that was what was in our minds.

L. J. Hirschman, M.D. (Wayne): I wonder if the wording could not be changed slightly and the word "Council" substituted for "Executive Committee?"

S. W. Insley, M.D.: In the last part of the resolution, in which it says: "Resolved, That the Executive Committee of the Michigan State Medical Society" —is that what you are referring to?

L. J. Hirschman, M.D.: We cannot refer things to the Executive Committee. The Council can refer them to the Executive Committee.

S. W. Insley, M.D.: I can only state as Chairman—but perhaps the other members of the committee will agree with me—that the wording should be: "RESOLVED, That the Council of the Michigan State Medical Society," etc.

The Speaker: The Chair will entertain a motion to substitute "Council" for "Executive Committee."

C. D. Brooks, M.D. (Wayne): I so move.

T. K. Gruber, M.D. (Wayne): I second the motion.

Henry A. Luce, M.D. (Wayne): Mr. Speaker, I object to the use of the word "Council," not because I do not respect the whole Council, but the Executive Committee is the active body of the Council. The Council meets twice a year. The Executive Committee is empowered to act for the Council. This is an action that must be taken at once. We dilly-dally along with this thing too long. I am opposed to referring it to the Council and favor referring it for action to the Executive Committee.

The Speaker: The Chair would like to correct Dr. Luce. This is the first time he has done anything wrong. The Council meets four times a year now, Dr. Luce, instead of twice a year, and so, do you want it to go that way in the record?

Henry A. Luce, M.D.: I accept the correction, Mr. Speaker, but do not detract at all from the efficiency of the Council.

The Speaker: Dr. Umphrey, our Councilman from the First District.

C. E. Umphrey (Wayne): I think this matter will be handled rather expediently because the Council meets on Thursday.

L. G. Christian, M.D. (Ingham): I think both of these resolutions were presented to supplement the report of the delegates to the American Medical Association. They are more or less an informative report.

The Speaker: Dr. Christian, if I may please, the point before the House is now whether to change this wording from Executive Committee to Council, and on that point only.

L. G. Christian, M.D.: I am sorry.

The Speaker: Is there further discussion on the motion? The motion is to change the wording from Executive Committee to Council. All in favor say "aye"; opposed. Will the "ayes" please rise. I don't believe we need to count it. Let's see the "noes." Will the "noes" please rise? The motion is carried, and the wording will be changed from "Executive Committee" to "Council."

Is there discussion on the main motion now? Dr. Christian, did you wish to speak?

L. G. Christian, M.D.: I see no reason to discuss it, with the excepton of the remark that both motions are thrown in for information. We believe that the House of Delegates should be informed that we need more information in Washington. As the Chairman of the Reference Committee said, the resolutions dovetail, one of them to take care of the House of Delegates and the Council of the Michigan State Medical Society, and the other to instruct the delegates to the American Medical Association to support Minnesota, Wisconsin, Iowa and the several states who brought in the motions last year.

We would like to have instructions from the House to carry back to the American Medical Association, to authorize the medical profession in the United States to become aggressive.

The Speaker: Are we ready for the vote on the main motion? All in favor of passing these two resolutions please say "aye"; opposed. Motion is carried. You know, with the amendment, it is referred to the Council to do the implementing.

XIV-6. TO ENLARGE FIELD ACTIVITIES OF AMA (VIII-10)

S. W. Insley, M.D.: The next motion considered was a motion by Dr. Gruber, which had to do with the proposition to change the structure and enlarge the field activities of the American Medical Association.

Your Reference Committee felt that a great deal of this matter had been gone over in the consideration of the previous two resolutions. It felt that any possible implications which might seem to be missed in these resolutions through here might well have been covered in the final resolution of the Luce-Christian Resolution, to the effect that the State Council will take such action as to implement our objectives in this matter.

Feeling as they did, the Reference Committee took no action, because of the previous actions taken with similar resolutions.

Mr. Chairman, your Reference Committee desires to report that they take no action because it has been covered before by previous resolution. I move that the report as such be rejected, with the understanding that it has been well covered in the previous resolutions.

W. B. HARM, M.D. (Wayne): I second the motion.

THE SPEAKER: Is there any discussion?

G. L. MCCLELLAN, M.D. (Wayne): The Chairman of the Committee used the word "reject." I wonder if he wishes to say that the resolution was rejected or that it was simply accepted without action.

L. G. CHRISTIAN, M.D.: This is Dr. Gruber's resolution. Dr. Gruber is well acquainted with this. He has converted me for this resolution, and I would like to have you talk with him. He has ideas that he can explain to this House of Delegates, as to the purpose of this resolution.

HENRY A. LUCE, M.D. (Wayne): Mr. Speaker, Members of the House of Delegates: I have the greatest respect for this committee of which Dr. Insley is chairman. I feel that their attitude has been the attitude which has characterized medical men down the centuries, the attitude, you might say, of pacifism. The Michigan delegates to the American Medical Association have studied this problem for a number of years and know that nothing short of positive, definite instruction from their own organization carries any weight.

I wish to be recorded in the minutes of the meeting as opposed to the recommendation of the Committee and approving the resolution as presented by Dr. Gruber.

THE SPEAKER: Is there further discussion?

THE SPEAKER: Dr. Gruber.

T. K. GRUBER, M.D. (Wayne): It isn't possible for each member of the House of Delegates of the Michigan Medical Society or any other group to be present at the meetings of the House of Delegates of the American Medical Association.

In Dr. Christian's report that he read last night, he stated that the anomalous situation arose in which the Secretary of the American Medical Association spent twenty minutes in haranguing the House of Delegates of the American Medical Association and telling them of the dire things that were liable to happen to the American Medical Association under the existence of the setup. He pointed out then the fact that the Department of Justice on several occasions had at least threatened the American Medical Association.

For instance, a certain state had told a graduate of medical school that they would not accept his internship in a hospital. The Department of Justice made inquiry and found that the American Medical Association had not accepted that hospital as a proper place to train interns, and they directed a letter to the American Medical Association and said: "How come? You people have already been told that you are under restraint of trade, and here you are telling a hospital that they cannot have an intern because you don't approve of the hospital, and that this man cannot have a license in a certain state because you don't approve of it."

They very quickly reversed their opinion and said, "All right. We will approve the hospital."

He further, at great length, pointed out that, for instance, the Social Security tax, I believe, amounted to a sum total of $70,000 a year. The American Medical Association just couldn't afford that, and if they taxed the income of the American Medical Association any further they wouldn't have any money left.

He cited several other instances of how the American Medical Association had been hoodwinked, had been told they were not what they ought to be, had been told that they had been already convicted, they were not paying taxes, and if these taxes were levied they would amount to $100,000 a year, and that under the existing setup the American Medical Association had no right to have a so-called lobby—that was the word that was used—in Washington, because the Department of Justice and the taxation group would light on them and would collect taxes and all that.

I talked with Dr. Olin West—he was the man—and he had talked at great length on two occasions, first before Reference Committee and, second, before the House—and I said, "Why doesn't the American Medical Association then reorganize under a different setup, so that they will be in position to carry on other than scientific, educational and charitable procedures?"

"Oh," he said, "that would ruin us!"

Now, I still believe that something very drastic has to be done in the matter of either reorganizing or revamping the whole structure of organized medicine to place organized medicine in position to do something.

Why is the National Physicians' Committee set up? Does anybody know? Well, I will tell you why, because the American Medical Association feels it is not in position under the present charter to handle the things that ought to be done for the men who are paying the dues and men who are expecting the House of Delegates of the American Medical Association to carry on the economic side of medicine. That is what the rank and file doctor thinks he is paying his dues for. And he is not getting anything for it. I don't blame him for kicking on the dues. I don't blame the men for saying, "Ten dollars for an assessment, a one dollar assessment—for what?" Economic? No. Political? No. Just educational, charitable and scientific. And outside of that, this House of Delegates has no business legislating anything. You have been legislating stuff here all the time, since we have been going on, and talking about this maternal-child welfare thing, which is an economic proposition. We haven't any business talking about it.

Get in line and talk about what you want to talk about, and let's not take the money from these men who are paying dues to keep this organization going. Don't go on with the idea of not letting your right hand know what your left hand is doing. With one hand you say, "We want the money paid to the individual." On the other hand, we say, "We want the money paid to the doctor." With the one hand we say, "We don't want any state help." With the other hand we say, "We want the State Legislature and lobby built for adult and child welfare to be paid to the doctor."

It is my contention that you should do either one thing or the other, either get your organization in position to handle the economic side of medicine as well as the charitable, scientific and educational or else quit business.

THE SPEAKER: Is there further discussion on the motion?

W. B. HARM, M.D. (Wayne): I would like to ask Dr. Gruber a question of information. Does any money go from the Michigan State Medical Society to the American Medical Association, or is the A.M.A. money all collected through its *Journal?*

T. K. GRUBER, M.D.: I believe you pay $8 a year for *The Journal,* one dollar of which is your dues and the other seven dollars is for *The Journal.* The rest of the cost of *The Journal* is made up from advertising.

W. B. HARM, M.D.: Anyone who does not take *The Journal* pays nothing to the A.M.A.?

T. K. GRUBER, M.D.: Anyone who doesn't subscribe to *The Journal* is not a Fellow of the American Medical Association.

W. B. HARM, M.D.: He is a member.

T. K. GRUBER, M.D.: He may be a member, but he cannot be a member of the House of Delegates of the A.M.A. unless he subscribes to *The Journal* and pays the full amount. He must subscribe for at least two years prior to his election.

THE SPEAKER: The Chairman of the Committee offers a word of explanation.

S. W. INSLEY, M.D.: I first would like to challenge a remark. It is the first time I think I was ever called a pacifist by Dr. Luce of Wayne. I think a great deal of this little misunderstanding at the present time is probably a matter of interpretation of words. I really think along the same line on these matters as Dr. Gruber and some of the other men who have spoken.

In the articles of incorporation of the State Medical Society, it happens to state that the purpose of the Society is to promote the science and art of medicine, the protection of public health, and the betterment of the medical profession.

Now we have been saying right along that some of these plans would inevitably result in a lower brand of medical care. We took the position that possibly the articles of incorporation covers the situation. The matters of interpretation is, I believe, a side issue, and I will not particularly fight one way or the other as long as the thing is clarified.

Is there further discussion on the original motion, which was to reject the resolution?

THE SPEAKER: Is Dr. Andrew S. Brunk in the House?

T. K. GRUBER, M.D.: May I ask the Chairman of the Council, on what grounds does the Michigan State Medical Society make representation to the various taxing bodies to relieve the Michigan State Medical Society from paying taxes on its income? May I ask if they do not represent to the various taxing bodies that they are a charitable, scientific, and educational organization? Is that not the basis on which they have arranged to be exempted from taxation?

A. S. BRUNK, M.D.: Those are the only grounds upon which they could request relief from taxation.

T. K. GRUBER: I believe, if the Secretary were free, he would tell you that the State Medical Society has made that representation not only to the State of Michigan but to the United States Taxing Bureau, and I know that is the basis on which the Wayne County Medical Society arranges to not have taxes on the income of the Society.

THE SPEAKER: Our Secretary, Dr. Foster, is present. He can answer that for us.

T. K. GRUBER, M.D.: May I ask the question, Dr. Foster: What is the basis on which the State Society represents that they should be relieved of the taxes?

L. FERNALD FOSTER, M.D.: The presentation of its charter and the definition of its aims and objectives.

T. K. GRUBER, M.D.: But what are the definitions?

L. FERNALD FOSTER, M.D.: The one that was read just a moment ago.

T. K. GRUBER, M.D.: I beg to differ, sir. I beg to state that I believe that I have read in the statements that, because they are a scientific, educational and charitable organization they are relieved of taxes. I at least presented that argument, not only from the State Medical Society but from the Wayne County Medical Society to the various taxation bureaus to have the Wayne County Medical Society relieved of taxes on the building at the corner of Canfield and Woodward. That is the only basis on which we have been able to argue the point.

L. FERNALD FOSTER, M.D.: But the determination which they arrived at was based on that, and they grant us that rating.

T. K. GRUBER, M.D.: But those are the points we put up, weren't they? Sure!

L. G. CHRISTIAN, M.D. (Ingham): This resolution is a very simple one. The delegation from the Michigan State Medical Society to the American Medical Association merely wishes your support to bring before the House of Delegates of the A.M.A. a matter for them to consider and to elaborate and enlarge their activities.

Dr. Gruber has the answer, as has the delegate from the Section on Radiology, and many other delegates that we talked to in that House of Delegates. It isn't a matter of policy, as I see it. It is a matter of work and a matter to be presented to the A.M.A., so that we can probably get our ears knocked off this time, but we will continue to present it.

That is the simple thing about it; we are merely asking your support to do something to attempt to wake up the folks at 535 North Dearborn.

T. K. GRUBER, M.D.: Yes, sir, that is the whole story.

THE SPEAKER: Is there further discussion?

R. H. DENHAM, M.D. (Kent): It strikes me that the purpose of this resolution is to get some dead wood out of the American Medical Association. It strikes me that that is the sole purpose of this resolution. They haven't said so in that many words, but they tell us how there are some crawling, talking people down there who are not doing anything, and maybe an editor who isn't doing what he should do, and that they are getting afraid of the cards. The whole thing boils down that they want to get rid of some dead wood. I don't know why they don't say it that way. But I don't think that is necessary. I think you are covered in the previous resolution.

W. B. COOKSEY, M.D. (Wayne): May I ask for information as to whether we are right in inferring that there is a possibility, should the American Medical Association assume a different role, a different kind of organization, if this bureaucratic medicine comes to a point where it looks as if we will be forced or they will try to force us to accept it, we can do something strenuous and radical? Is it possible that it puts us in a position of extreme usefulness and perhaps power for our own good, similar to a labor organization?

I would further like to know if a labor organization which has some of these powers that I suspect we need, that I suspect this resolution is driving at, is taxed?

T. K. GRUBER, M.D.: Mr. Speaker, may I say that labor organizations, to my way of understanding, do not pay taxes. Their strong forte is credit, whatever that may be. You can interpret that any way you want to, but that is their strong forte. At the present time I do not believe they pay taxes. But I think you have hit the nail on the head. I think Dr. Cooksey has asked the question. The idea in mind is to implement the American Medical Association to the point that they are in position to assume an entirely different role in the matter of trying to get their story across, not only to the public but to the legislators in Washington.

At the present time they are well convinced that they have no right to go down to Washington and say to a legislator, "Please, Mr. Legislator, would you listen to my story?"

R. V. WALKER, M.D. (Wayne): Mr. Speaker, in support of these first two resolutions, granting that this last resolution is similar to the first two, why not support our delegates to the A.M.A. as much as we can, a little more than the first two, if it is only a little bit more? We want the same thing. We want to support them. If it is going to call for an amendment or reorganization of A.M.A. let's do it this year instead of next year.

I will make an amendment to the motion before the House to the effect that disapproval of the committee be rejected and that the original resolution be accepted.

THE SPEAKER: That would not be an amendment.

I have been thinking about that little problem, because I thought it was coming up. If it would be agreeable to the House, the Speaker will handle it this way:

We will take a vote on this first, and if this motion to reject is defeated, then I will ask for another motion.

R. V. WALKER, M.D.: May I speak once more then? Let me make a plea to have this motion defeated.

THE SPEAKER: Are you ready for the question?

ERNEST N. D'ALCORN, M.D. (Muskegon): One doesn't like to talk about one's family affairs, but our county society has a means of being self-sustaining, has an income, in other words, by the endeavors of the members of the Society, so we built up a fund.

We had this fund and we had an income from the fund. We didn't pay any tax because we stayed within these three limits. We said we did, but the Federal Government didn't think we did, because we paid the members' dues. They said we had an income, so they sued us, and they collected. We paid our back taxes. So here is a possibility that the AMA is right, that if we do anything outside of those three things we are going to have to pay the Federal taxes.

THE SPEAKER: Are you ready for the question? The motion before the House is to reject the resolution as presented.

The Speaker will now state it, as he understands it. The motion was made by the Chairman of the Reference Committee that the Committee would reject the resolution that was offered by Dr. Gruber. Is that correct? Do you all understand it? All in favor say "aye"; will you please rise? All opposed.

R. V. WALKER, M.D.: May I have the floor for a minute? I made a plea a minute ago to vote "no" to reject the motion that the Chairman made. That is what we need.

THE SPEAKER: We will ask Dr. Insley what it is that he wanted rejected.

S. W. INSLEY, M.D.: It was the feeling of the Reference Committee that these purposes and aims had been at least fairly well covered in the previous resolutions of Dr. Luce and Dr. Christian. When I moved to reject the resolution here, I was referring to the specific resolution contained in the report, having nothing whatsoever against the Gruber report. I simply felt that the problem had been well covered in the previous report.

R. V. WALKER, M.D.: Mr. Speaker, my argument was to vote "no," which would mean not to accept this committee's report, so that in parenthesis, we would later make a motion to accept the resolution as it was submitted by Dr. Gruber. By voting "no" you are rejecting Dr. Insley's committee's report. You are turning it down. You are not accepting his report, and "no" means that you are not accepting his report.

THE SPEAKER: The motion was to reject the resolution as made by Dr. Gruber.

S. W. INSLEY, M.D.: May I ask for a question? I am perfectly willing, with the consent of the committee, to clarify this thing. I will be perfectly willing to withdraw my motion, through the Chair, and have suggestions for a new motion.

THE SPEAKER: Are the members of the House willing to have Dr. Insley withdraw his motion?

DELEGATES: Yes.

THE SPEAKER: Are you willing Dr. Gruber?

We will now entertain a new motion.

R. V. WALKER, M.D. (Wayne): Mr. Speaker, I would like to make a motion for the House of Delegates to accept the resolution as presented by Dr. Gruber, as a means of adding increased implements for the House of Delegates to the American Medical Association from this Society, to give them adequate support.

My motion is to accept the original resolution.

E. A. OAKES, M.D. (Manistee): I second the motion.

THE SPEAKER: The motion is to accept the original resolution as offered by Dr. Gruber. Are you ready for the question?

T. K. GRUBER, M.D. (Wayne): Mr. Speaker, I want to state the reason I voted as I did, was so I would be in position to ask for reconsideration in case the motion was lost.

G. L. MCCLELLAN, M.D. (Wayne): If the sense of the House is to approve Dr. Gruber's resolution in order to give it more force. I would like to ask the maker of the motion to substitute the word "approve" rather than accept." Acceptance does not necessarily carry approval.

THE SPEAKER: I will take exception to that. To accept and to approve are the same. To receive is different. If you wish to make the change, it is all right with me.

Are you ready for the question? All in favor say "aye"; opposed, "no." Any noes? The original resolution as offered by Dr. Gruber is accepted.

XIV-6. "INSTITUTE ON PUBLIC HEALTH ECONOMICS" (VIII-3)

S. W. INSLEY, M.D.: The next resolution which your Reference Committee considered was one from Dr. Brasie, in regard to the "Institute on Public Health Economics." The resolution was adopted unanimously by the Committee.

Mr. Chairman, I move the adoption of this resolution.

L. W. HULL, M.D. (Wayne): I second the motion.

THE SPEAKER: Is there any discussion on the motion? All in favor of the motion say "aye"; opposed. Carried.

XIV-6. ACTIVITY OF RED CROSS (VIII-15)

S. W. INSLEY, M.D.: We had another resolution introduced by Dr. Gorsline in relation to the Red Cross.

Your Reference Committee on this matter did not feel that it had sufficient factual data at hand to take any stand at the time on this matter. The Committee recommends that the matter, for the time being, be tabled. I so move.

THE SPEAKER: There is a motion to table this resolution.

W. B. COOKSEY, M.D. (Wayne): I second the motion.

THE SPEAKER: All in favor of the motion say "aye"; opposed. The motion is carried.

XIV-6. TO LIMIT MICHIGAN MEDICAL SERVICE TO DOCTORS OF MEDICINE (VIII-5)

S. W. INSLEY, M.D.: We next have a resolution by Dr. Brasie.

The Reference Committee adopted this attitude, after studying the matter and going over it in great length:

"The Commitee endorses the principles involved in this resolution and recommends to the House that the Council of the Michigan State Medical Society be instructed to consider the problems and implications involved and to report its findings and recommendations to the Society through the pages of THE JOURNAL and through the Secretary's Office to Michigan Medical Service prior to January 1, 1944."

The Committee adopted this last suggestion, with one exception, on which Dr. Brasie I think will have a minority report.

The Committee wishes to adopt the last resolution, and, Mr. Chairman, I move its adoption.

ROBERT S. BREAKEY, M.D. (Ingham): I second the motion.

D. R. BRASIE, M.D. (Genesee): Is it in order to submit a minority report, a substitute for this?

THE SPEAKER: After this is submitted. That minority

report can be accepted in lieu of this after it has been passed.

HENRY COOK, M.D. (Genesee): Mr. Chairman, I would like to ask for the privilege of Dr. Brasie to make his minority report as a substitute motion, in order that both sides might be discussed before the first one is put.

THE SPEAKER: No, we can't accept it as substitute motion at this time.

HENRY COOK, M.D.: Well, then what is the use of making a minority report?

ROBERT S. BREAKEY, M.D. (Ingham): Mr. Speaker, Dr. Brasie feels very strongly about this motion, and it was the only dissenting vote, so he did not entirely disagree with the sense of the remainder of the committee. I am inclined to agree with Dr. Cook. Before we vote on a problem which is so controversial as is this one, certainly Dr. Brasie's side of the question should be heard. He is not moving. He is proposing a minority report. It was the sense of myself, as a member of the committee, that before any action was taken all minority reports should be read along with the majority reports to compare the situation.

E. A. OAKES, M.D. (Manistee): Do I understand correctly that the doctor can have the floor and discuss the motion, without making a minority report in the form of a motion?

THE SPEAKER: That is correct.

ROBERT S. BREAKEY, M.D. (Ingham): Dr. Brasie is still a member of this committee.

I rise to a point of order. The entire report of the commitee is not yet in.

THE SPEAKER: The Speaker is not absolutely sure on that point. We will look it up in Robert's Rules of Order in a minute or two, but perhaps some of our older parliamentarians can answer that for us. Is Dr. Luce here?

This question has arisen, and while we are looking it up, probably some of you who go to AMA can answer it.

Dr. Insley has brought in the report. There is a motion on the floor. He has moved that it be accepted. That motion has been seconded. Now Dr. Brasie wishes to bring in a minority report or offer a substitute motion, to read his minority report and offer a substitute motion that that be approved in place of the other. Is it correct to vote, first, on a majority motion, a majority report, and then give Dr. Brasie a chance to give the minority report?

Dr. Insley, the Chairman of the Committee, has given the majority report, and there is a motion on the floor to accept that report, which has been seconded. Now Dr. Brasie asks the privilege of presenting his minority report at this time and offering a substitute motion to take that in place of the original motion.

HENRY A. LUCE, M.D. (Wayne): My opinion would be that the Speaker of the House of Delegates should accept the minority report as a substitute motion, and then vote on that. If you reject it, then you go back to the original motion.

THE SPEAKER: Thank you. Are the members of the House willing to accept Dr. Luce's opinion, supported by my own in his authority on this matter? All in favor say "aye"; all right, Dr. Brasie.

D. R. BRASIE, M.D. (Genesee): Thank you, gentlemen.

I might say that the only reason, really, for presenting a minority report was to avoid the thing that occurred here on the House floor a little while ago. I did not want the question presented whereby a negative vote had a "yes" on the floor and vice versa. So it may come before the floor in its original form as much as possible, the minority report is made, not particularly as a quarrel with the Committee.

I might say that I am grateful to the Committee for enforcing the principles involved here, although quite honestly, I don't see how they could have done much otherwise.

"Now, feeling that the majority report on this resolution constitutes a gentle form of whitewash; and being in doubt that the Council of the Michigan State Medical Society, having had knowledge of the payment to osteopaths and others by Michigan Medical Service, and having taken no action to date to correct same, will not take positive action to correct this condition without specific direction and mandate of the House of Delegates, therefore, this minority report recommends:

"1. That the report of the majority on this subject be not accepted and

"2. That the House of Delegates affirm the principle that osteopathic care is not medical care and that osteopaths and other irregular practitioners be not paid for services rendered certificate holders of Michigan Medical Service, and, further, that the original resotion as read be passed."

Mr. Speaker, I offer this as a substitute motion for the motion made by the Chairman of the Committee, which constituted the majority report.

THE SPEAKER: Is there a second to Dr. Brasie's motion?

HENRY COOK, M.D. (Genesee): I second it.

THE SPEAKER: This, gentlemen, is a substitute motion to adopt the minority report in lieu of the majority report. Is there discussion on this substitute motion?

S. W. INSLEY, M.D. (Wayne): Being both a member of the Michigan Medical Service as well as a member of this House of Delegates, I am aware of the tremendous legal difficulties in this whole question. I, however, do not wish to say too much on this matter myself here tonight, but I am going to ask Dr. Novy if he will make a few remarks concerning this problem.

D. R. BRASIE, M.D.: I would like to discuss my own motion.

THE SPEAKER: That is quite correct. It is your motion that is before the house.

D. R. BRASIE, M.D.: Gentlemen, the facts, as stated in this resolution, that practitioners other than doctors of medicine are paid and have been paid, are substantiated by a letter addressed to the Council of the Michigan State Medical Society on May 26, 1943, entitled—gentlemen, with your permission I will read the letter, because it states the history fairly well of what has occurred, and I think that this information should be spread on the record and be there for your information. It also states quite clearly the position of the Michigan Medical Service at this time on this question, and in all fairness to Michigan Medical Service and everybody else, it should be presented.

It is addressed to the attention of A. S. Brunk, Council Chairman.

In accordance with the resolution adopted by the Executive Committee of the Michigan Medical Service at its meeting of May 12, 1943, this letter is written to advise your hody, the Council, of the situation existing in regard to payments for services rendered hy doctors of osteopathy to suhscribers of the Michigan Medical Service. We understand that your hody has previously heen advised of this situation in the past, although unofficially, without request for advice from the Council.

At the time of the original issuance of the surgical certificate hy the Michigan Medical Service to the Ford Motor Company employes, in March 1940, and from that time on, suhscribers receiving services from osteopathic physicians have heen reimbursed as a refund at the prevailing schedule of henefits. In the case of the Ford Motor Company, payments were made to osteopathic physicians hy the Welfare Division of the Ford Motor Company, the amount so paid heing deducted from the monthly remittance of the subscription rates.

When the Chrysler Corporation, and in turn, the General Motors Corporation and numerous other large corporations were enrolled, commitments were made agreeing to deal with claims for services rendered hy osteopathic physicians as refunds or reimbursements to suhscribers, and this has heen the practice until October 2, 1942, at which time the Medical Advisory Committee of the Michigan Medical Service adopted the following resolution:

"No benefits to he payahle for services of other than doctors of medicine, except under special consideration to he determined hy the Medical Advisory Committee."

However, due to a great number of complaints, both from subscribers and from group contracts, because of the enforcement of this resolution, a further resolution was adopted by the Medical Advisory Committee on December 2, 1942. A complete review of the situation relative to services rendered by practitioners other than doctors of medicine was made. In regard to such services, the facts relative to the emergency of the services are to be obtained and benefits to be authorized to the subscribers only where circumstances warrant. Prior to payment of any benefit, a check is to be made as to the licensure status of the practitioner. Under this resolution, claims for services rendered by osteopathic physicians have been dealt with as reimbursements to subscribers.

In referring to reimbursements or refunds, we mean that a Michigan Medical Service check is not used in payment to the physicians, as in the case of a doctor of medicine, but that a cashier's check is secured, payable to the subscriber patient in the amount of the appropriate item in the schedule of benefits, refunding to the subscriber that amount toward the charge made by the doctor of osteopathy.

The Executive Committee of the Michigan Medical Service is convinced that it has no alternative but to continue to so treat such services, and the method of payment, if it is to retain its present subscribers and fulfill the commitments made, in accordance with the customs established during the operation of the Corporation since the inception of the surgical certificate.

The comments of the Council of the Michigan State Medical Society in regard to this situation and its continuance are earnestly solicited.

The following is a motion passed at the joint meeting of the Medical Advisory and Executive Committees of the Michigan Medical Service, Wednesday, May 12:

"Osteopathic Situation. After discussion, motion made, seconded and carried that the Council of the Michigan State Medical Society be informed thoroughly of the situation in regard to relationship between the Michigan Medical Service and osteopaths, asking for early comments.

"B. Motion made and seconded and carried that the management be authorized to treat claims for services rendered by osteopathic physicians in accordance with customs and practices established prior to October 1942."

Now this letter is a very interesting one. In regard to payment of osteopaths, the subject of this resolution covers it.

In the first place, it states that the first time osteopaths were paid was when the Ford contract was reviewed, and it is in connection with that Ford Contract that the resolution states that they did seek and obtain from the Attorney General's office a ruling, under which they might pay osteopaths.

Now, you will bear in mind once more the wording of the resolution, which clearly shows, as you know, that we were told the benefit was that osteopaths would not be paid. We were sold on that basis. It was one of its benefits.

Also when it became apparent that the Ford Motor Company would not advance to Michigan Medical Service a contract unless osteopaths were paid, right at that moment, the officers of the Michigan Medical Service, their Executive Committee, who were constituted right and who have appeared before us on the floor and have assured us that payment will be made to doctors of medicine only, those same men, and the Executive Director at that time, Mr. Laux, under their control, obtained a ruling from the Attorney General and, without coming before the House, proceeded to act upon it.

Now, this ruling very definitely can be read in total, if you wish, but the pertinent parts of it are these:

First, our answer is simply to the rendition of emergency service.

Second, in the Act there appears this phrase: "that such other benefits may be added from time to time as the Corporation may determine with the approval of the Commissioner of Insurance."

Now, on the basis of that phrase, "such other benefits may be added," they proceeded to pay osteopaths.

As the contracts were presented, as I remember very clearly, two years ago, here, the General Motors Contract was about to be confirmed. As a matter of fact it had been confirmed and approved before the House of Delegates ever met. The Council at that time certainly must have known that that contract could not be made without the payment of osteopaths. If they did not know that, gentlemen, were they functioning?

And yet they proceeded to conclude another contract with General Motors which also permitted the payment of osteopaths without coming before the floor of this house, advising you of the conditions under which Michigan Medical Service evidently must continue if it is to continue in any way.

Now, this same Council—the majority of that Council still sits, and they have had two and one-half years' time to bring this before the floor of the house. They have made no attempt whatever to do so.

One of the arguments against bringing this resolution before the floor at the present time is that it is two and a half or three years too late, that a precedent has now been established, and that we should have brought this motion before the floor of the House two and a half or three years ago.

I submit to you, gentlemen, that the letter from Michigan Medical Service states that the Ford contract was made in March of 1940. I submit to you that in 1940 there was a meeting of the House of Delegates. In 1942 there was a meeting of the House of Delegates, and today. And only now, after full possession of the facts, are we able to come before you with the proper knowledge to back up such a resolution.

I also maintain that we should not have to have been the ones to bring this to your attention.

Now, if it is the price of the continuation of the Michigan Medical Service that we pay osteopaths and others, let's note in the early days of the Michigan Medical Service, the principles under which it was established were sacrificed to that expediency. Such is always the demand of business.

Gentlemen, I think the resolution speaks for itself. It is rather difficult for us—for me at least—and for men in our county to feel that we have struggled along, if you wish to put it that way, that your body has built up an organization which you support, and then that you turn around and give the benefits to the osteopaths.

One other point about the emergency ruling. An emergency ruling would seem to be, to an ordinary observer, an occasion when no other individual was available to render the service or when other individuals so available could not be reached, and there would seem in the ordinary course of events to be few.

However, bearing on the question of emergency is the amount of money which indicates the number of services rendered by osteopaths. This morning, before the Committee, some figures were presented that I was to present, and undoubtedly Dr. Novy will comment upon them in his way. However, the four leading osteopaths of the state of Michigan, their gross receipts so far, in 1943—now there are other figures but we want to cut it as short as possible—are:

Doctor No. 1, whose name I have here, but I don't care to spread it on the record unless you insist, so far in 1943 has received, and he is a doctor in our county, $6,079.50.

Doctor No. 2, who supposedly is in Wayne, has received so far this year $7,003.

Doctor No. 3—I don't know where he is—has so far received $6,980.

Doctor No. 4, has received $5,944.

Gentlemen, in the words of the English language, as I understand them, that does not constitute an emergency.

Now, one further thing, and these figures are approximate. I understand that within the first year this was done, approximately 1.3 per cent of all funds in the Michigan Medical Service went to practitioners other than doctors of medicine, but in the second year that figure had jumped to somewhere close to three per cent, over two, and that this year so far the percentage paid to osteopaths runs five per cent. It does

not sound like much money, five per cent, but in a corporation that runs as large as this does, it is a considerable amount.

You, through your organization, are subsidizing osteopaths. I ask you to support this document. Thank you. (*Applause*)

THE SPEAKER: Is there further discussion on this motion? Is there further discussion on this motion of Dr. Brasie's to accept the minority report? That is, in lieu of the report made by the Committee, the majority report.

R. L. NOVY, M.D.: There is one thing in the letter that was not read. That was the signature—"R. L. NOVY, President."

D. R. BRASIE, M.D.: I am sorry, sir. My apology.

R. L. NOVY, M.D.: That letter was sent to the Council in order to make perfectly clear the exact situation. That letter, I believe, was not known to Dr. Brasie until I handed it to him. Is that correct?

D. R. BRASIE, M.D.: That is correct, sir.

R. L. NOVY, M.D.: Furthermore, the information that you gave was obtained and handed to you without your request, in regard to percentages and so on.

D. R. BRASIE, M.D.: Yes, that is true. All except the copy of the Attorney General's report. That has been obtained by formal request.

R. L. NOVY, M.D.: Dr. Brasie made the request for the Attorney General's report. Knowing that he wanted that, the other information was provided him.

The situation that we have here is the situation that this letter intended to clarify and it was written for that purpose. It antedates this meeting last spring. It was done to clarify and to put on the record exactly what it did.

At the meeting of the Steering Committee, the Resolutions Committee, upstairs, Dr. Brasie and I agreed that if Dr. Brasie did not read it I was going to read it. It is a public record.

The situation that we have is just this. In 1940, through a subterfuge, the osteopaths were paid, paid by the Ford Motor Car Company, and those payments deducted from the premiums that rightly belonged to the Medical Service. That allowed the Medical Service at that time to say they were not paying osteopaths.

I entirely agree with Dr. Brasie that that was a definite subterfuge. At that time the decision should have been made as to what was going to be done and it should have been thoroughly clarified three years ago. It was not done.

We have inherited that setup. We have that on our hands. The subsequent contracts that were entered into carried along with them, although not in the contract, by agreement, the osteopathic provision. That is in the correspondence. It is not clearly stated. It has always been evasively stated in the correspondence, but the subscribers who took the contract were led to believe that they would have osteopathic service if they so desired. That is the situation that has come before the Medical Service. The question of clarifying that has been brought up repeatedly.

We had commitments then definitely on that score. The claims were there. The directors and the Executive Committee have many times gone over the possibility of what could be done. How could it be done? We attempted last fall, as Dr. Brasie read, to clip the wings of that thing, and we found that we were in a jam. We could not clip the wings, because there had been commitments made for us. We found ourselves in a jam in this respect also, that we are at the present time still in the red, although our earnings have in the last eight months gone along steadily.

We find ourselves in this position: If anything is done to cut down, getting out of the red, it is the duty of the Commissioner of Insurance to step in. If the Commissioner of Insurance steps in, there is no Board of Directors, and the policy will be maintained.

Until such time, in other words, as we get out of the red, we cannot change those policies, because it would interfere with the progress of recovering out of the deep red that we have been in.

After you are once out of the red, you can do then as you please. It is evident that because of the commitments made and because of the position taken by the General Motors and other corporations, that would not countenance anything but that concession, that their contracts will be cancelled if we carry through, we cannot do so at the present time as long as we still are not above the red line.

As soon as we are in the black, if you care to do so, that can be done.

Gentlemen, one thing that goes a little further, and that is this problem of the osteopath, and it is a problem that you have been facing for years, and you have made no decision on it, not in regard to the Michigan Medical Service but to the practice of osteopathy in all its phases, surgery and otherwise. It infringes on your practice every day, and you have made no decision about it.

There are several things that can be done. You can look at this problem, right straight in the face, and see where it is.

First of all, you have history to direct you in some thinking. Forty to fifty years ago there was a school known as the homeopathic school, that stood in that time in just as good disrepute as the osteopaths of today. No member of the regular medical profession would consult with a homeopath. They would not allow a homeopath in any hospital that was considered reputable. Hospitals by homeopaths were established, such as Grace Hospital in this city, but no regular doctor would go into Grace Hospital. It was an outcast hospital.

The pressure at that time was so great that there was established in the University of Michigan a School of Homeopathy, on the same pressure that we have today with your osteopaths. That school, with the University of Michigan, was established by an act of Legislature. It was the only school in the University of Michigan that could not be abolished by the Board of Regents of the University of Michigan. The University of Michigan was empowered and could have abolished the Medical School, but it could not have abolished the Homeopathic School. That was the fight that was on some years back.

It was on the same grounds that you used today, inadequate schools, poor preparation, poor training, and so on. You are facing that same problem of the osteopath today. It is no different than what you had then, and you have had it right before you. It is a question of whether the osteopath legitimately can practice medicine in the state of Michigan. You have made no effort to decide that by carrying it through to a supreme court.

There are two extremes on the handling of that situation. Nebraska, with laws similar to the state of Michigan, has carried through to their supreme court the problem, and it has been ruled that the osteopath can practice osteopathy, but he cannot practice anything else that the school of osteopathy might chance to teach him. If the school of osteopathy by chance should teach him actuarial experience, he couldn't become an actuary. If the school of osteopathy by chance taught him surgery, he couldn't become a surgeon.

Nebraska so ruled. The osteopath could not become a surgeon. He could practice osteopathy, massage in its various forms, but not surgery. That was just an adjunct to what he was being taught.

There is another extreme, and that is the state of New Jersey. I have here a telegram that I will read to you because it is exactly the other extreme. This

was obtained since this discussion started, and it reads as follows:

> Since 1941, osteopathic graduates having equivalent educational standards demanded of M.D's are licensed to practice medicine and surgery. Board of Medical Examiners recognizes Philadelphia and Los Angeles schools only as having standards of Grade A medical schools. The Surgeon General of the Navy is now authorized under recent laws to appoint graduates of reputable osteopathic schools as medical officers.

I am also informed that the Surgeon General has inspected at least one of these schools, presumably the Philadelphia School, and on his recommendation, if they add two courses, their men will be eligible for commissions. One of those courses is in Tropical Medicine, which very few schools have put in until recently. Wayne, for instance, has just put it in. The other is a course on Public Health.

Furthermore, New Jersey has gone far enough to say that if the osteopaths will qualify themselves by taking adequate courses in surgery, they will qualify them, and some 213 have been accepted as practicing physicians and surgeons in New Jersey.

You have two extremes in handling this problem, one in Nebraska and one in New Jersey. You have a precedent in history of handling exactly the same situation.

Now I definitely deplore the subterfuge that was used or the "on the quiet" setup that was used by the Michigan Medical Service in paying osteopaths. That was why I had that letter sent to clarify the situation. It was there on our hands, and we had to face it. You have still got to face it.

Irrespective of what is done at the present time, until that deficit is out, you have still got to face it.

I am asking, therefore, that this resolution, Dr. Bracie's substitute resolution, be rejected, and that the resolution put in by the committee, requesting the Council to get busy and decide what they are going to do on this question, make it clear, be brought out. Thank you.

THE SPEAKER: Is there further discussion on Dr. Brasie's motion?

L. W. GERSTNER, M.D. (Kalamazoo): As a delegate, I am confused, and I am sure that I could not represent in a motion of my own, the opinion of my constituents in my County Society. I believe this problem should some way be allowed to be taken back to the constituent societies for the opinion of the members of those constituent societies.

THE SPEAKER: May I say, in answer to that, that that can be done very easily if this is referred to the Council. It will be referred to the County Medical Societies for study.

That is not an argument. I don't want to leave that impression.

Is there further discussion on Dr. Brasie's motion?

GEORGE WATERS, M.D. (St. Clair): Mr. Chairman, it would seem to me, after listening to all this discussion and the reading of this information that was imparted to us, that there has been a very flagrant disregard of the intent of the Michigan Medical Service as organized. I would not be fair to my own county if I did not raise my voice here in regard to this matter.

We in our county are very much opposed to the paying of osteopaths. Now I realize that we are in a jam, financially, as has been suggested, that we should not do anything until such time as we are out of the red.

I don't believe in subterfuge. I believe in coming right out in the open and placing the cards on the table. I don't know how this can be handled, but I still think that it is too bad that in an organization such as we have, it can be controlled by labor and have to stoop to subterfuge to carry on.

I believe that we should take some very definite steps to see that this thing is changed and changed immediately.

THE SPEAKER: Is there any further discussion?

(Calls for the question.)

THE SPEAKER: It is now twenty minutes to twelve. How many resolutions do you have left? There are five more resolutions besides this one. I would like to ask your pleasure. Would you like to carry through and finish all our work tonight, or would you like to have a session tomorrow morning? Those who think it might be better to have a meeting tomorrow morning, will you please raise your hands? This will not be an official vote, just so I know something about it. Those who would rather carry through until we finish our work tonight.

That satisfies me. We will carry on.

Are you ready for the question then on Dr. Brasie's motion?

S. W. INSLEY, M.D.: May I make one remark at this time? If you will recall, the so-called subterfuge—that is the word used—started back two or three years ago. Two or three, and maybe more, of the top executives of the organization at that time are not now in the company. God knows, that since last fall the men that you elected at your last meeting have done their best to try to get this thing straightened out. They have worked hard. They have sought every avenue of escape to try to get this thing ironed out in satisfactory fashion. You cannot decide the whole question tonight.

I might add one little afterthought, that if Dr. Brasie's motion is followed through to conclusion, all the hard work for the last year will be for nothing.

THE SPEAKER: Are there any who would like to have Dr. Brasie's resolution read once more?

(Calls for the question.)

All in favor of Dr. Brasie's substitute motion, to accept the minority report in lieu of the majority report of the Committee, please say "aye." Will you please rise, so we will see how many. Those voting "no," please rise. The motion is lost.

We are now ready then to vote on Dr. Insley's motion.

All in favor of Dr. Insley's motion, which is to accept the majority report, please rise. The "noes", please rise. I believe it is plain. The "ayes" have it and the motion is carried.

Will you read the next one?

W. B. COOKSEY, M.D. (Wayne): Mr. Chairman. I am sorry to take time at this late hour. Personally, I would like to speak a word in commendation to Dr. Brasie. I was a strong proponent of the Michigan Medical Service. I had heard nothing of this. I have been horrified by what has been going on, as have a good many around met at both sessions where this has come out. I think the House of Delegates owes Dr. Brasie a very definite vote of thanks for bringing this on the floor. It seems to me that Dr. Novy has well expressed our crucial problem in regard to it.

A few months ago I discussed with a group of men in one of our leading hospitals—there were twelve or fifteen men—the fact that I had been called in consultation at the Osteopathic Hospital and had gone a couple of times and made up my mind I would never go again. In the course of the discussion it was brought out that there were five men in the room, out of twelve or fourteen, who had seen patients in consultation at the Osteopathic Hospital. These men were members of the Wayne County Medical Society. Some were still doing it, but were unhappy about it.

It seems to me this thing ought to be brought to a focus so, as Dr. Novy says, we have something definite and I strongly urge the Council to do something for next year so we know more about it.

THE SPEAKER: I am sure I speak for every delegate here when I say that we all recognize Dr. Brasie and Dr. Novy as two of our most valuable members.

XIV-6. TO CHANGE THE FORM OF MICH. MEDICAL SERVICE (VIII-4)

S. W. Insley, M.D.: We have another resolution introduced by Dr. Brasie.

Your Reference Committee opposes the adoption of this resolution for the following reasons:

1. That the resolution is based upon a false premise in that payments by the Michigan Medical Service to physicians is not analogous to the payment of governmental moneys to physicians.
2. Michigan Medical Service is in no way a subsidy or governmental controlled project.
3. Michigan Medical Service funds are not tax moneys.
4. Michigan Medical Service is operated under the provisions of a special enabling act and such payments of indemnities to policy holders instead of physicians for service would require operation under former insurance laws, and this would require recapitalization and reorganization.

Your Reference Committee, considering these facts as well as others, decided to oppose Dr. Brasie's resolution, and substituted the remarks which I have just read for the purposes of the record.

Mr. Chairman, I move that Dr. Brasie's resolution be not adopted.

The Speaker: Is there a second to that motion?

C. F. Brunk, M.D. (Wayne): I second the motion.

D. R. Brasie, M.D. (Genesee): I have only one comment to make about that. The premise may or may not be wrong in the eyes of the doctors on the floor of this House, but to the laity I think there is no distinction, that I can find by questioning many people, between the doctor who receives money direct from Michigan Medical Service for services rendered and those doctors who might receive money direct from the Federal government for service given. The laity can see no distinction.

(Calls for the question.)

The Speaker: All in favor of Dr. Insley's motion, which is to reject the resolution offered by Dr. Brasie, say "aye"; opposed. The motion is carried.

XIV-6. WAGNER-MURRAY-DINGELL BILL (VIII-2)

S. W. Insley, M.D.: We have next a resolution introduced by Dr. Witwer. The Reference Committee adopted the resolution in its entirety and simply added one extra paragraph. I will read the resolution, including the extra paragraph added.

Whereas, The Wagner-Murray-Dingell Bill S-1161 was introduced into Congress June 3, 1943, and

Whereas, This bill is of utmost importance to all physicians in the United States because it proposes the establishment of a unified social insurance system which would provide limited benefits for and extract extra tax payments from practically every employed person in the United States; and

Whereas, The annual expenditure provided for in this bill would be, in round figures, $3,000,000,000, or the approximate maximum total annual revenue of the Federal Government from all sources up to 1933; and

Whereas, The introduction of such a program would necessitate the creation of an additional tax-supplied bureau; and

Whereas, It is estimated that approximately 110,000,000 people would be subject to its medical provisions, which would be administered by one man; namely, the Surgeon General of the United States Public Health Service; and

Whereas, The proposals of this bill are a definite menace to the true democratic principles of every American citizen and are particularly vicious as regards their application to the Doctors of Medicine; therefore be it

Resolved, That a united medical profession take all necessary precautions to see that such proposed legislation is not permitted to become law; and be it further

Resolved, That the House of Delegates of the Michigan State Medical Society in executive session assembled September 20, 1943, strongly opposes in all its implications and possible amplifications, the Wagner-Murray-Dingell Bill; and be it further

Resolved, That we are equally opposed to all other schemes which would lead to any proposed compulsory sickness insurance, whether organized, controlled or administered by any branch of the Government; and be it further

Resolved, That all County Medical Societies and their individual members be advised to maintain and practice vigorous opposition against the gradual governmental instrusion into the practice of medicine; and be it further

Resolved, That we, as members of the Michigan State Medical Society, shall use every means at our command to combat the aggressive attempts of the proponents of State Medicine to socialize the practice of medicine during the present emergency, when many of our members are serving in the Armed Forces.

Your Reference Committee unanimously approves of the above resolution, with the one added paragraph, and, Mr. Chairman, I move its adoption.

The Speaker: Is there a second to Dr. Insley's motion?

A. E. Stickley, M.D. (Ottawa): I second the motion.

(The motion was carried.)

XIV-6. EDUCATIONAL FUND (VIII-1)

The Speaker: Before we take up the next resolution, the Chair would like to justify himself a little bit. On that resolution for the establishing of the educational fund, there was, I know, by those who sponsored that, considerable disappointment, and I can well understand that, but I want you to know that the Chair was right in accepting that vote without debate. I refer to the vote to lay on the table.

Rule No. 3 on a motion to lay on the table reads as follows: "Cannot be debated or amended."

So on that resolution, you gentlemen who are so much in favor of that understand the ruling of the Chair. Is that clear?

All right. Then we are ready now for the next resolution.

XIV-6. PROGRAM OF OBSTETRIC-PEDIATRIC CARE FOR SERVICE MEN'S WIVES (VIII-14)

S. W. Insley, M.D.: This resolution was introduced by Dr. Oakes, and it has to do with the program of Medical Nursing and Hospital Maternity and Infant Care for wives and infants of certain enlisted men.

L. G. Christian, M.D. (Ingham): I move that the House go into executive session to consider this resolution.

D. R. Brasie, M.D. (Genesee): I second the motion.

The Speaker: The motion is made and seconded that the House now go into executive session. All in favor of this motion please say "aye"; opposed. Will the "ayes" please rise. Please rise once more, those in favor of going into executive session. Opposed please rise. The motion is carried, and I will ask Dr. O'Meara, who is Sergeant-at-Arms as well as Chairman of the Credentials Committee, to clear the House.

Executive Session

The House went into Executive Session, and after full discussion, took the following action regarding the Federal Program of Obstetric-Pediatric Care for Servicemen's Wives:

"Because this plan is a form of state medicine, the Michigan State Medical Society refuses to coöperate in any of the provisions of the plan in the present form.

"That until satisfactory adjustments in the program can be made, the members of the Michigan State Medical Society are requested to give medical care gratis in order that the wives and children of servicemen may obtain hospital care."

The House also discussed the Gruber Resolution re: Taxation on Medical Homes, and referred it to the MSMS Legislative Committee for study and action.

VII-3. TESTIMONIAL TO MICHIGAN MEDICAL MEN IN MILITARY SERVICE

I would like to call now on Dr. J. E. Brook, one of our Past Presidents, a man who represented us at the AMA for many years, just for one word. He had something he wanted to say or do. Dr. Brook, it is a pleasure to call on you.

J. D. Brook, M.D.: I would like to present, at this late hour, for about one moment, the following: We were talking about the servicemen's wives. Now I would like to talk for a moment about the doctors who are in the service and some of them who passed on. I would like to present the following:

While here assembled in annual session, it seems fitting and proper that we give recognition to the services rendered by hundreds of our members who are serving in the armed forces in defense of our country, often in surroundings and under conditions too terrible to imagine. Therefore, shall we express to our absent members, through our State Journal, our sincere hope and wish for their success and their safe return, at the conclusion of a successful conflict; and further, I would move that this House of Delegates do honor to those of our members who have made the supreme sacrifice on the field of battle, by standing for a moment with bowed heads in their memory.

(The audience rose and stood in silent tribute to the members of the Society who had died on the field of battle.)

The Speaker: Thank you very much, Dr. Brook. It is certainly good to see you on the floor.

I wonder if those Past Presidents who are still here will please rise? I see Dr. Brook and Dr. Perry.

XV. Elections

XV-1. COUNCILOR OF ELEVENTH DISTRICT

We will proceed now, gentlemen, to the election of the Councilor from the Eleventh District. Nominations are now in order.

Ernest N. D'Alcorn, M.D. (Muskegon): I would like to nominate Dr. Stryker.

H. R. Moore, M.D. (Newaygo): I support the nomination.

C. A. Pauksits, M.D. (Mason): I move the nominations be closed, and the Secretary instructed to cast the ballot.

Harold D. Dykhuisen, M.D. (Muskegon): I second the motion.

(The motion was carried. The Secretary did so cast the vote.)

The Speaker: Dr. Stryker is elected. Congratulations, Dr. Stryker.

XV-2. COUNCILOR OF TWELFTH DISTRICT

Now the next is the election of a councilor from the Twelfth District. Nominations for that office are in order.

Henry E. Perry, M.D. (Luce): Delegates of the House, I think Dr. A. H. Miller of Gladstone has represented the Twelfth District for five years and has made a very good official. I, therefore, place his name in nomination to succeed himself as councilor for the Twelfth District.

R. V. Walker, M.D. (Wayne): I second the nomination, and I move that the nominations be closed and the secretary instructed to cast the unanimous ballot.

The Speaker: There is a motion that the nominations be closed and the Secretary be instructed to cast the unanimous ballot in favor of the election of Dr. A. H. Miller.

C. E. Simpson, M.D. (Wayne): I second the motion.

(The motion was carried.)

The Speaker: The Secretary has so cast the vote. Dr. Miller is elected.

XV-3. COUNCILOR OF THIRTEENTH DISTRICT

The next is the Thirteenth District. Nominations for that office are now in order.

H. T. Sethney, M.D. (Menominee): I would like to present W. H. Huron's name to succeed himself.

The Speaker: Dr. W. H. Huron has been nominated to succeed himself.

(The nomination was seconded.)

R. J. Armstrong, M.D. (Kalamazoo): I move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot.

R. V. Walker, M.D. (Wayne): I second the motion.

(The motion was carried, the Secretary did so cast the vote, and W. H. Huron, M.D., of Iron Mountain, was re-elected.)

XV-4. DELEGATES TO AMA

The Speaker: Delegates to the American Medical Association. Two such vacancies exist. Nominations are now in order.

E. R. Witwer, M.D. (Wayne): I would like to nominate a man who has had all the vicissitudes, trying to fight the so-called problems of the AMA. That man is thoroughly versed in meeting all the problems. He knows how to do it and has been doing it all these years. He is a delegate from Ingham County. Therefore, I wish to place in nomination the name of L. G. Christian.

The Speaker: Dr. Christian's name has been placed in nomination. Are there other nominations?

J. J. O'Meara, M.D. (Jackson): I would like to support the nomination of Dr. Christian to succeed himself.

The Speaker: Are there other nominations?

A. E. Catherwood, M.D. (Wayne): I would like to place in nomination a man who has represented this state for several years in the AMA and has done a very good job, F. E. Reeder of Flint.

R. B. Brasie, M.D. (Genesee): I beg the privilege to second that.

The Speaker: Are there other nominations?

J. J. O'Meara, M.D. (Jackson): I move the nominations be closed and the Secretary be instructed to cast the unanimous ballot for the two men.

Harry F. Dibble, M.D. (Wayne): I second the motion.

(The motion was carried, the Secretary did so cast the vote, and Dr. Christian and Dr. Reeder were elected.)

XV-5. ALTERNATE DELEGATES TO AMA

The Speaker: The next order is election of Alternate Delegates to the House of Delegates of the American Medical Association, and there are two vacancies. Unfortunately, one of our Alternates, whom we all knew so well, Dr. Greene, has died, and his place is vacant.

G. L. McClellan, M.D. (Wayne): I would like to place in nomination the name of the present incumbent. He has rendered medicine very valuable service over a great many years, Dr. Pino.

The Speaker: Dr. Ralph H. Pino has been placed in nomination by Dr. McClellan.

Are there other nominations? We have another to be elected. It requires at least two persons to be nominated.

C. F. SNAPP, M.D. (Kent): I should like to place in nomination a man who has been very active in this House of Delegates for a number of years. He served on many committees and has done a mighty fine job, Dr. E. A. Oakes of Manistee.

PALMER SUTTON, M.D. (Oakland): I would like to place in nomination the name of Howard H. Cummings.

THE SPEAKER: Dr. Oakes and Dr. Cummings have been placed in nomination. Are there other nominations?

If not, we will proceed with the election. There are three nominees for two vacancies. The vote will have to be by ballot, and the one getting the highest number of votes will be the Senior Alternate. The one getting the second highest number will be the second alternate.

I will appoint as tellers, Dr. Catherwood of Wayne, as Chairman; with Dr. D'Alcorn of Muskegon and Dr. LaBine of Houghton as the tellers.

The ballots will now be passed.

Gentlemen, there are two or three ways of doing it. I think the simplest way is to vote for two, and the one getting the highest number of votes will be the Senior Alternate and the one getting the second highest number of votes will be the second alternate.

(The votes were cast and counted.)

THE SPEAKER: The result is Pino, 52; Oakes, 34; and Cummings, 34.

E. A. OAKES, M.D. (Manistee): Mr. Speaker, in view of the time, may I withdraw my name? Dr. Cummings is much my senior and is much better qualified than I am.

THE SPEAKER: Dr. Oakes, there is a regular way of handling that without delay.

E. A. OAKES, M. D.: That is all right.

THE SPEAKER: That being the case the result of the election is this: that Dr. Pino is Senior Alternate, and Dr. Cummings is second alternate.

XV-6. PRESIDENT-ELECT

The next order of business then is the election of the President-Elect. Nominations for that office are in order.

F. E. REEDER, M.D. (Genesee): Mr. Speaker and Members of the House: It is a long time since I faced you from this platform. It is a long time since I had to go down and knock somebody down. But tonight I have the privilege, the pleasure, and a happy one indeed, to present to you the name of one of our members for President-Elect, a very fine gentleman, a man who has stood for organized medicine many, many years. He has been a wheel horse. He has been faithful. He has labored hard. He knows organized medicine from alpha to omega. He has been a member of the Council for thirteen years. He has been Chairman of the Council for three years. I know of no man within our group who is better qualified to meet with the doctors as well as with the other people.

It gives me great pleasure, members of the House, to nominate and present the name of Dr. A. S. Brunk of Wayne, Detroit.

THE SPEAKER: Thank you, Doctor. Dr. Brunk's name has been placed in nomination.

E. A. OAKES, M.D. (Manistee): Mr. Speaker, may I have the very great honor of seconding that nomination? I have known Dr. Brunk a great many years in the House of Delegates, and I want to second what Tony Reeder has said. There isn't a better man in the Society this year.

L. G. CHRISTIAN, M.D. (Ingham): The Ingham County delegation seconds the nomination of Dr. Brunk.

THE SPEAKER: Thank you, Dr. Christian. Are there other nominations?

If not, the Chair will entertain a motion that the nominations be closed and the Secretary be instructed to cast the ballot.

(Upon motion regularly made and seconded, the nominations were closed and the Secretary was instructed to cast the ballot.)

THE SPEAKER: The ballot is so cast, and Dr. Brunk is elected.

At this time I would like to ask Dr. A. S. Brunk to come to the platform for a moment. Dr. A. S. Brunk. (Applause). I would like to appoint Dr. Reeder and Dr. Basil Connelly, Dr. Gruber, Dr. Christian, and Dr. Umphrey to escort him to the rostrum.

(Dr. Brunk was conducted to the platform.)

F. E. REEDER, M.D. (Genesee): Mr. Speaker, it is a pleasure to present the President-Elect.

THE SPEAKER: Thank you, Dr. Reeder.

Before we ask our President-Elect for a few words, I am going to perform one of the most pleasant duties that I have had for many days, in putting, Dr. Brunk, right on this side, a little tag that says "President-Elect, A. S. Brunk," and with it go my best wishes and, should I say, blessings, old boy.

(The Speaker pinned the badge of the President-Elect on Dr. Brunk's coat.)

Now we would like you to say a few words.

(The audience rose and applauded.)

PRESIDENT-ELECT BRUNK: Mr. Speaker and Members of the House of Delegates: I am sure if I would make a speech at this time it would be perhaps the best means of clearing this house, and you gentlemen would go home and get some sleep. I shall not impose upon you at all.

I want you to know that I consider this a very great honor and also a very great responsibility, and in the years to come, when there are many problems for organized medicine, I shall try to assume my share as nearly as I possibly can.

I want to thank you very much for this very distinct honor. (Applause)

XV-7. COUNCILOR OF SIXTEENTH DISTRICT

H. F. DIBBLE, M.D. (Wayne): I now move that we declare the Sixteenth Councilor District vacant.

C. E. SIMPSON, M.D. (Wayne): I second the motion.

(The motion was carried.)

THE SPEAKER: Nominations for Councilman from the Sixteenth District, which is the eastern half of Wayne County, are now in order.

R. V. WALKER, M.D. (Wayne): I would like to nominate, as the result of the caucus of the Wayne delegation, E. R. Witwer. You all know Ernie Witwer. You know the kind of man he is. I guess you know the kind of councilor he would make.

THE SPEAKER: Thank you. Dr. E. R. Witwer has been nominated by Dr. Walker, Chairman of the Wayne Delegation. Are there other nominations?

W. D. BARRETT, M.D. (Wayne): I would like to support the nomination of Dr. Witwer and move that the nominations be closed and the Secretary instructed to cast the unanimous ballot for Dr. Witwer.

L. G. CHRISTIAN, M.D. (Ingham): I second the motion.

(The motion was carried.)

THE SPEAKER: The Secretary has cast the vote. E. R. Witwer is now our Councilman for the Sixteenth District.

Before we go on to the next order of business, I would like to take this occasion to thank every delegate. I want to thank especially the committeemen and the chairmen of the committees and Dr. Stanley Insley, in particular, because he has had a tough assignment, and he knew it when he took it.

You have all been very nice to me during the year.

There is one other group that I would like to thank especially, and that is the members of the Council, and particularly the Executive Committee. For three years now, they have overlooked my shortcomings. You know, I am one of those fellows who sometimes speaks first and thinks afterward, and each one of these men has overlooked that, has given me credit for all the good and none of the bad.

The next order of business is the election of a Speaker. Nominations are now in order.

XV-8. SPEAKER, HOUSE OF DELEGATES

ALFRED LABINE, M.D. (Houghton): I would like to place in nomination the present incumbent, Dr. Ledwidge.

THE SPEAKER: The present incumbent's name has been placed in nomination. I will ask the Vice Speaker to take the chair.

(The Vice Speaker, G. Howard Southwick, M. D., took the chair.)

ALFRED LABINE, M.D. (continuing): I think Dr. Ledwidge has convinced us all that he has our support. There still are troubled waters, and we would like to have him carry on.

THE VICE SPEAKER: Are there any other nominations?

A. E. STICKLEY, M.D. (Ottawa): I should like to second the nomination of our present Speaker to continue in office for at least another year. I am sure every member of this House of Delegates appreciates the very fine work Dr. Ledwidge has given us. He has not only proved himself a very masterful presiding officer, but he has also been very efficient and untiring in his work throughout the year in the Council and with the various committees, which his office calls upon him to perform.

J. J. O'MEARA (Jackson): Mr. Speaker, I move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot for Dr. Ledwidge for Speaker.

A. E. STICKLEY, M.D. (Ottawa): I second the motion.

(The motion was put to vote, the ballot was cast, and P. L. Ledwidge of Wayne was re-elected Speaker.)

(Dr. Ledwidge resumed the chair.)

THE SPEAKER: I thank very much. I did not know that it was going to be so easy or I wouldn't have shed the tears.

I have one other thing to do, and that is to thank Dr. G. Howard Southwick, who has supported me these two years. He has been very helpful in keeping up the morale. He always has something funny to say, which you fellows don't hear, that helps out a lot in these long sessions.

I want to thank especially Dr. Foster and Mr. Burns, the executive officer, for the work that they have done during the year. Perhaps some of you don't know this, but about the first of June, or a short time before that, Lynn Leet, who was Mr. Burns' right-hand man, was called into the service, and it left a lot of extra work. On top of that, in June, no fewer than three of Mr. Burns' office force of four walked out because they could make more money elsewhere. So he was left with that burden and one girl, and I am telling you there is a lot of work in that office and he deserves a vote of thanks.

XV-9. VICE-SPEAKER, HOUSE OF DELEGATES

The next order of business is the election of a Vice Speaker. Nominations are now in order for a Vice Speaker.

A. V. WENGER, M.D. (Kent): It gives me pleasure to nominate the present incumbent, Dr. Howard Southwick.

THE SPEAKER: Dr. Howard Southwick has been placed in nomination by Dr. Wenger of Kent.

A. E. STICKLEY, M.D. (Ottawa): I second the nomination.

E. A. OAKES, M.D. (Manistee): I move the nominations be closed and the Secretary cast the ballot for Dr. Southwick.

(The motion was seconded.)

HOWARD SOUTHWICK, M.D. (Kent): Gentlemen, I appreciate the compliment. I have been privileged to officiate at the arduous duties of a Vice Speaker here for a couple of years, and you know how hard I have worked at it. This year I thought I would stay up here all the time, just to see how strenuous it was.

When I took this position two years ago, I thought some day probably I would carry on through and be the Speaker of the House. Having tried to pinch-hit for the present Speaker a couple of times today, I find that a physicial disability that I have, which is the loss of acuity of hearing, has interfered with my ability to handle the meeting properly. Therefore, I desire to retire as Vice Speaker and allow the House to elect some man who will be trained up through the process of being Vice Speaker, so that he may some day, when Dr. Ledwidge wishes to retire, occupy the place of Speaker of the House.

R. V. WALKER, M.D. (Wayne): In view of what Dr. Southwick has said, I would like to place in nomination the name of Dr. C. F. Snapp of Grand Rapids, for the position of Vice Speaker. Dr. Snapp has been coming here for a good many years. We all know him in the House of Delegates and otherwise. I don't think that, after Dr. Southwick's withdrawal, we could find a better man.

THE SPEAKER: Dr. C. F. Snapp of Kent has been nominated.

A. E. STICKLEY, M.D. (Ottawa): I take pleasure in seconding that.

C. F. SNAPP, M.D. (Kent): Mr. Speaker, I wish to thank Dr. Walker and all these brother delegates for their kind remarks and for their thoughtfulness in placing me in nomination, but I am like Dr. Southwick. We are a bunch of cripples up in Grand Rapids. I wouldn't be physically able to take on that work. I am sorry, but I would be very glad to do all I can for the Society in every way although I certainly could not take that position. Thank you very much.

THE SPEAKER: Dr. Snapp withdraws his name from nomination, for a very good reason, which we know is true. That is the only reason we would let you off.

G. L. MCCLELLAN, M.D. (Wayne): There is a man who has impressed us a great deal by the manner in which he has handled affairs. I would like to place in nomination the name of Dr. Oakes.

THE SPEAKER: Dr. E. A. Oakes' name has been placed in nomination by Dr. McClellan of Wayne.

A. V. WENGER, M.D. (Kent): I support that.

THE SPEAKER: Are there any other nominations?

C. E. SIMPSON, M.D. (Wayne): I move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot for the election of Dr. Oakes.

(The motion was seconded and carried.)

THE SPEAKER: The vote has been cast and Dr. Oakes is elected.

Before you go, the State Society wishes to thank the Wayne County Medical Society for its courtesy.

(The meeting adjourned at 3:15 a.m.)

State Health Commissioner Dies

H. Allen Moyer, M.D., Charlotte, Health Commissioner of Michigan, died on January 6, 1944, at the age of sixty-seven. A fitting necrology to the memory of Dr. Moyer will be published in the February number of THE JOURNAL.

MICHIGAN'S DEPARTMENT OF HEALTH

H. ALLEN MOYER, M.D., Commissioner, Lansing, Michigan

COLDS AND PNEUMONIA REPORTED ON INCREASE

Colds and pneumonia are attacking more persons in Michigan than is usual at this time of year, according to state health department reports, and Commissioner Moyer declares that the possibility that influenza may become epidemic in coming weeks must be recognized.

"We have no way of foretelling whether we face epidemic conditions approaching those of 1917 and 1918 or whether we may have to contend with the disease in as severe form," says Dr. Moyer.

Recent dispatches from England describe the current influenza wave in that country as the worst since 1937. Michigan authorities say that wartime air travel can spread the disease around the world even more rapidly than was the case in the last war.

BLOOD PLASMA IS SENT TO TEN MICHIGAN CITIES

Stocks of blood plasma have been sent by the state health department's Lansing laboratories to ten Michigan communities whose residents have given blood for the establishing of plasma reserves.

The plasma has been processed in the Lansing laboratories from blood collected during visits of a traveling clinic to Lansing, Dowagiac, Holland, Cadillac, Midland, Boyne City, Big Rapids, Manistee, Owosso and Sturgis. The operating expenses of the traveling clinic are met from a $20,000 special appropriation voted by the last legislature. Funds for the plasma processing were made available by discontinuing the manufacture of pneumonia serums.

The clinic will continue to visit Michigan communities where sufficient volunteer donors are recruited by local Red Cross chapters. The Red Cross completes local arrangements, supplying additional nurse personnel, quarters, canteen service and transportation.

The stocks of plasma are apportioned among communities on the basis of units of blood supplied locally by donors. Hospitals in which reserves are maintained will furnish plasma, free of charge, to local physicians. The Lansing laboratories will maintain plasma reserves also to meet emergency needs anywhere in the state, the Office of Civilian Defense having first priority on plasma which is packaged in 1,000 c.c. units for its purposes.

Plasma now being processed is in liquid form and is stored at room temperature.

WARNING ON TULAREMIA ISSUED BY DEPARTMENT

Warning to hunters to watch for signs of tularemia in wild rabbits has been given by the state health department. The acute communicable disease has been recognized in ground squirrels and other small rodents but wild rabbits are the animals that are most often infected. The disease is spread among animals through the bite of the rabbit tick, the wood tick and certain species of biting flies and can be transmitted to humans by infected insects.

The following precautions are advised: Always wear rubber gloves when dressing wild rabbits, do not handle rabbits that are found dead or that appeared slow or sluggish when they were shot, cook rabbit meat thoroughly and destroy all rabbit meat if internal organs are studded with small white spots.

MENINGITIS, MEASLES EPIDEMICS ARE LIKELY

There has been no sharp over-all increase in the communicable diseases in Michigan during two years of war although diphtheria, meningitis, tuberculosis, measles and the venereal diseases are on the rise, the state health department reports.

Mass migration to Michigan industrial areas from other states is largely responsible for upturns in diphtheria and meningitis while case-finding measures employed by industry in pre-employment examinations and by Selective Service are boosting totals in tuberculosis and venereal disease classifications.

The department warns that a meningitis epidemic of major proportions is likely in 1944. Large-scale distribution of sulfonamides to private physicians and health officers has been undertaken by the department as a meningitis control measure.

Michigan is approaching the peak of the three-year cycle of epidemic measles and it is expected that 80,000 or more cases will be recorded by next summer. A more severe type of measles is being reported now.

NEW RECORD IN BIRTHS WILL BE SET IN 1943

Michigan will set a new record in number of babies born in 1943—an estimated 127,000 on basis of ten months' figures—while holding the infant death rate close to the 1942 all-time low of 37.02 per 1,000 live births, the state health department reports.

Last year's births totaled 124,068, a previous all-time high. Births through October, 1943, totaled 104,929 and 3,966 deaths of infants under one year were reported for the period. The infant death rate for the first ten months of 1943 was 37.80 per 1,000 live births.

In 1900 the state's infant death rate was 159.08 per 1,000 live births.

BIRTH RECORD DEMAND DROPS FROM 1942 PEAK

A dwindling demand for copies of birth records is reported by the state health department. Through November, 1943, the department made 48,868 searches of records and issued 32,835 copies of birth records. All-time record for searches was established in 1942, when the department made 121,328 searches largely because of industrial and Selective Service demands for proofs of citizenship.

two shortcuts in URINALYSIS

Galatest (DRY REAGENT FOR URINE SUGAR)

Time involved—30 seconds!

Acetone Test (DENCO)

Time involved—one minute!

Acetone Test (Denco) and its companion product Galatest are two tests which are rapidly simplifying "routine" urinalysis in doctors' offices, hospitals, induction centers—every place where speed and accuracy are of vital importance.

Acetone Test (Denco) detects the presence or absence of acetone in urine in one minute. Color reaction is identical to that found in the violet ring tests and equally easy to differentiate. A trace of acetone turns the powder light lavender—larger amounts to dark purple. Acetone Test (Denco) is available in vials containing enough powder for over 125 complete tests, also in combination kits with Galatest.

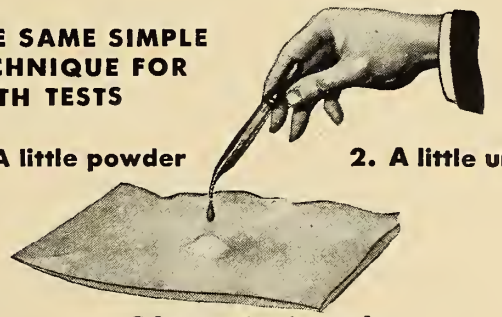
Accepted for advertising in the Journal of the American Medical Association





A carrying case containing one vial of Acetone Test (Denco) and one vial of Galatest is now available. This is very convenient for the medical bag or for the diabetic patient. The case also contains a medicine dropper and a Galatest color chart. The handy kit or refills of Acetone Test (Denco) and Galatest are obtainable at all prescription pharmacies and surgical supply houses.

THE SAME SIMPLE TECHNIQUE FOR BOTH TESTS



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Color reaction instantly

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Woman's Auxiliary

EXECUTIVE BOARD MEETING

The Executive Board of the Woman's Auxiliary to the Michigan State Medical Society held its eighteenth mid-year meeting and luncheon November 22, at the Wayne County Medical Society Headquarters, Detroit.

Mrs. John J. Walch of Escanaba, state president, in her report stressed the importance of this year's work, and urged every member to do her utmost toward achieving the main objectives for the year. The first great task will be the determined coöperation of all members to defeat the pending Wagner-Murray-Dingell bills. The second task is the nation-wide campaign to recruit girls for the nursing profession. Mrs. Walch also reported on the national board meeting she had just attended in Chicago. Committee Chairman and County presidents gave splendid reports and had added material and zest to bring back to the members of their County Auxiliaries. There were twenty-four in attendance.

* * *

Subscribe to the Bulletin

* * *

UNITED STATES CADET NURSE CORPS

Most County Auxiliaries in the State of Michigan have their program for the recruitment of High School Seniors in the United States Cadet Nurse Corps well under way.

There is a splendid article on this project in the September, 1943, *Bulletin of the American College of Surgeons,* which all County Presidents and Program Chairmen are urged to read if possible. In this article all who are concerned with the success of this great war service are urged to make use of a film that will aid their publicity greatly. It is "R.N. Serving All Mankind." It is available in 16 mm. or 35 mm. size and may be obtained direct from the distributor, Burton Holmes Films, Inc., 7510 North Ashland Avenue, Chicago, Illinois, at a service charge of $1.75 plus carrying charges.

Rose M. Ohmart,
Program Chairman

* * *

HOUGHTON-KEWEENAW-BARAGA COUNTIES

Mrs. John J. Walch of Escanaba, state president of the auxiliary to the Michigan State Medical Society, and Mrs. Otto Hult of Gladstone secretary, were guests of honor at the November meeting of the Houghton-Keweenaw-Baraga Medical auxiliary in Calumet.

INGHAM COUNTY

Mr. William J. Burns, executive secretary of the Michigan State Medical Society, spoke on the Wagner-Murray-Dingel bills which advocate government control of medicine, at an afternoon luncheon meeting of the auxiliary to the Ingham County Medical Society at the home of Mrs. J. K. Heckert, East Lansing, Miss Olive Sewell, executive secretary of the Michigan State Nurses' Association spoke on the recruitment for the United States Cadet Nurse Corp.

Mrs. Berten M. Davey a beloved member of long standing of the Ingham County Auxiliary died suddenly in November. She gave unstintingly her services to the community. Mrs. Davey was organizer and principal promoter of the annual President's Ball for the benefit of infantile paralysis sufferers, was committee woman of the Democratic State Central Committee and for twenty-one years was choir director and organist of the Church of Resurrection. She was also active in the Matinee Musical, a member of the St. Lawrence Hospital Auxiliary, and the League of Catholic Women.

* * *

JACKSON COUNTY

The Jackson county medical auxiliary packed and sent 32 Christmas boxes to members of the Jackson County Medical Society in service. The auxiliary supplied cookies at the Service Men's Center. They entertained Mrs. John J. Walch at a special meeting and tea at The Hotel Hayes on November 20.

* * *

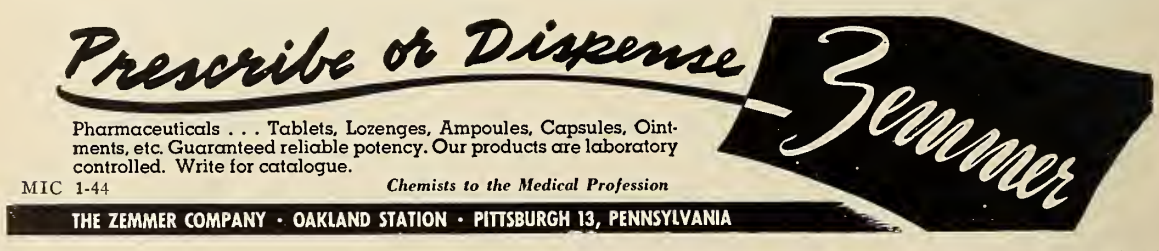
ST. CLAIR COUNTY

The Auxiliary to the St. Clair County Medical Society had a supper meeting at the home of Mrs. Clyde S. Martin, November 9. Mrs. H. J. Burley, chairman of Nurses Education and Mrs. A. L. Callery broadcasted a skit over station WHLS, Pt. Huron, concerning the U. S. Cadet Nurse Corps. Mrs. Burley has also had the film, "R.N. Serving All Mankind" and it has been shown to all Senior High School girls in the county.

* * *

MSMS SECRETARIES CONFERENCE

Officers of the Woman's Auxiliary to the State Society and the Presidents of the District Auxiliaries have been invited to the "School of Information" which will be featured at the Secretaries Conference of January 30, 1944, Book-Cadillac Hotel, Detroit, 10:00 a.m. to 4:30 p.m.



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COUNTY AND PERSONAL ACTIVITIES

G. Lombard Kelly, M.D., Dean of the University of Georgia School of Medicine, Augusta, Georgia, has been appointed Secretary of the new Council on Medical Service and Public Relations of the AMA.

* * *

AMA Annual Session will be held in Chicago, June 12-16, 1944. The meetings of the House of Delegates of the AMA will be held at the Palmer House; the Scientific Exhibits will be at the Palmer House; the Technical Exhibit will be housed in the Stevens Hotel.

* * *

Joseph L. Posch, M.D.; Bert E. Stofer, M.D., and John Winslow Hinshfeld, M.D., Detroit, are authors of an original article entitled "Salmonella Choleræ Suis as a Cause of Indolent Subcutaneous Abscess" which appeared in the JAMA of November 27, 1943.

* * *

"We wish to emphasize that the medical profession must take all necessary steps to counteract the gradual intrusion by bureaucratic agencies in the practice of medicine. Failing in this effort, the individual physician will soon lose his status if not his individuality. Every member of the Michigan State Medical Society should realize the importance of this particular problem." Report of Reference Committee on Annual Report of The Council, MSMS, Detroit, September 21, 1943.

* * *

A. C. Henthorn, M.D., St. Johns, was elected president of the Clinton County Medical Society at its meeting of November 8. P. F. Stoller, M.D. of Fowler was chosen as vice president and T. Y. Ho, M.D. of St. Johns was re-elected as secretary-treasurer for the twenty-first year.

W. B. McWilliams, M.D. of Maple Rapids was chosen as delegate and G. H. Frace, M.D., of St. Johns was elected as alternate.

The Society's meeting date has been changed to the second Monday of each month, from September to May inclusive.

* * *

The Michigan Pathological Society held its bimonthly and annual meeting at the Henry Ford Hospital, Detroit on December 11. The subject of the meeting was a seminar on "Pathology of the Eye" which was presented by Parker Heath, M.D., of Detroit. The members of the Society had been previously furnished with sets of slides of pathological material for study.

At the business meeting the following officers were

ADVANCED COURSE IN APPLIED ANATOMY

University of Michigan Medical School

Second Semester—March 9 to June 29, 1944

Thursday—1:00 to 10:00 P.M. each week

East Medical Building

Professor Rollo E. McCotter

Dissection of specific regions of the body to refresh previous knowledge and as preparation for surgical specialties or investigative work. If time permits and suitable material is available, the study may be extended to the microscopical and developmental anatomy of the region. Informal lecture the first part of the afternoon followed by dissection of the part under consideration. Graduate or postgraduate credit can be arranged. Fee $25.

Registration: Room 2040, University Hospital or in the Anatomical Laboratories, East Medical Building.

DEPARTMENT OF POSTGRADUATE MEDICINE

University of Michigan

Ann Arbor, Michigan

elected for 1944: President, Dr. D. C. Beaver, Detroit; President-elect, Dr. S. C. Howard, Ann Arbor; Secretary-Treasurer, Dr. S. E. Gould, Eloise and Councillors, Dr. H. E. Cope, Lansing (1 year); Dr. H. R. Prentice, Kalamazoo (2 years).

* * *

Talks against attempts to regiment medicine were presented recently by (a) L. Fernald Foster, M.D., MSMS Secretary—Bay City Junior College, November 8, Bay City; American Medical Association Secretaries' Conference, November 20, Chicago. (b) Wm. J. Burns, Executive Secretary—Lansing Rotary Club, October 29, Lansing; Kent County Woman's Auxiliary, November 10, Grand Rapids; Ingham County Woman's Auxiliary, November 15, Lansing; Lansing Lions Club, November 16, Lansing; Bay County Medical Society and Women's Auxiliary, November 17, Bay City; Lansing Exchange Club, November 29, Lansing; Jackson Civic Group, December 14, Jackson.

* * *

Every Little Bit Helps.—There is a critical need for medical and surgical supplies that may lie hidden and forgotten in your office: discarded or tarnished instruments . . . surplus drugs . . . vitamins . . . infant foods. Collected, packaged, sent to the Medical and Surgical Relief Committee, 420 Lexington Avenue, New York, they can play a vital role in its program of medical relief for the armed and civilian forces of the United Nations.

Surgical instruments and medicines are sought after by physicians and pharmacist's mates of our Navy . . . are hungrily snatched by the medical corps of our allies. The work of war zone hospitals and welfare agencies is too often crippled by the lack of medical supplies. Community nurseries in this country, refugee camps abroad cry out for vitamins and baby foods for their ill-nourished charges.

* * *

The Annual Clinic Day at Mt. Carmel Mercy Hospital, Detroit, will be held January 26, 1944, beginning at 9:00 a.m. in the Auditorium.

Program

"Tropical Diseases"—Robert S. Hettig, M.D., Ann Arbor.

"Experimental Treatment of Cancer"—H. C. Connell, M.D. of Kingston, Ontario.

"Rectal Surgery"—Tom E. Jones, M.D., of Crile Clinic, Cleveland, Ohio.

"Obstetrical Problems"—Harold Henderson, M.D., Detroit.

"Gall Bladder Disease"—Frederick A. Coller, M.D., Ann Arbor.

"Diseases of the Liver"—C. C. Sturgis, M.D. of Ann Arbor.

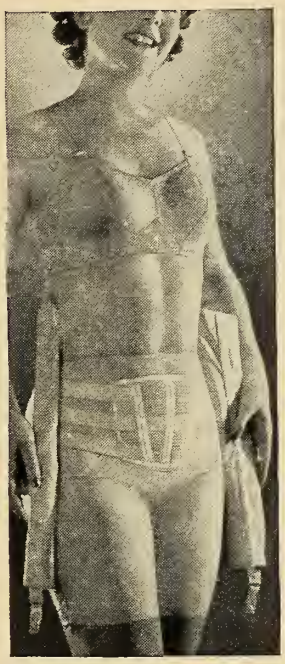
"Meningitis in Children"—Norman C. Bender, M.D., of Buffalo, New York.

"Reidal Strauma of the Thyroid Gland"—Joseph L. DeCourcy, M.D., of Cincinnati, Ohio.

Dean E. H. Norris, M.D., of Wayne University and Eugene C. Keyes, M.D., Lieutenant Governor, will be the luncheon speakers.

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Sacroiliac Sprain or other Back Injury?

Spinal Arthritis or Sciatica?

Postoperative Conditions?

Maternity or Postpartum Conditions?

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Every Spencer Support is individually designed for the patient of non-elastic material. Hence, the support it provides is constant, and a Spencer can be—and IS—guaranteed NEVER to lose its shape. Spencer Supports have never been made to *stretch to fit;* they have always been *designed to fit.* Why prescribe a support that soon loses its shape and becomes useless before worn out? Spencers are light, flexible, durable, easily laundered.

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Some straws in the wind are indicated by the following items which may affect you as a physician in private practice. One item appeared in a recent issue of *The National City Bank Bulletin* from New York to the effect that Social Security Taxes payable by both employe and employer effective January 1, 1944, will be doubled. A check-up on this at the local office of the Social Security Board indicates that they have had no official confirmation about it as yet. They say that the same provision was intended to be put into effect on January 1, 1943, but at the last moment Congress intervened by ordering no change for 1943. The other item appeared in a November 8 tax service letter from one of the leading publishers, reading as follows: "The Army and Navy have notified Ickes and Bowles of their gas requirements for first six months of 1944. Amount is so great that first reaction was that all A and B books would have to be terminated and a substantial number of C's. Look for a sharp cut in values of A and B books and severe limitations upon C's."

* * *

General Magee Named Executive Officer of Informational Service.—Prof. Ross G. Harrison, chairman of the National Research Council, has announced the appointment of Major Gen. James Carre Magee, Medical Corps, United States Army, retired, as executive officer of the Informational Service of the Council's Division of Medical Sciences. This service has been established by the National Research Council under the recent grant of the Johnson and Johnson Research Foundation, by which the sum of $75,000 was made available to the council for the period ending June 30, 1945. The purpose of the grant was to enable the council to assemble and disseminate, as far as possible medical information pertaining to the war effort.

General Magee retired last May as Surgeon General of the Army. He recently received the Distinguished Service Medal for his accomplishments in the office. On assuming his new duties, he will devote full time to the organization of a central office in the National Research Council which will collect medical reports and records widely dealing with military medical practice, civilian practice as affected by the war, medical education and research and the distribution of diseases. The materials collected will, so far as military necessities permit, be made available by publications, summaries and notes.

* * *

COMING MEETINGS

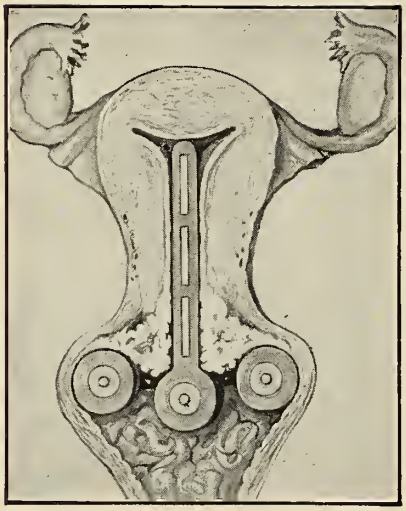
American Medical Association, Chicago, June 12-16, 1944.

Michigan State Medical Society Postgraduate Conference on War Medicine, Grand Rapids, September 27, 28, 29, 1944.

National Conference on Medical Service, Chicago, February 13, 1944.

Annual Congress on Medical Education and Licensure, Chicago, February 14, 15, 1944.

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TESTIMONIAL TO MICHIGAN MEDICAL MEN IN MILITARY SERVICE

The 1943 House of Delegates of the Michigan State Medical Society, at its Detroit meeting of September 21, stood in silent tribute to those Michigan Doctors of Medicine who have died on the field of battle in the present war.

The following testimonial to all our Michigan military men (1,857) was presented to the House of Delegates by J. D. Brook, M.D., Grandville, Past President of the Michigan State Medical Society:

"While here assembled in annual session, it seems fitting and proper that we give recognition to the services rendered by hundreds of our members who are serving in the armed forces in defense of our country, often in surroundings and under conditions too terrible to imagine. Therefore, shall we express to our absent members, through our STATE JOURNAL, our sincere hope and wish for their success and their safe return, at the conclusion of a successful conflict; and further, I move that this House of Delegates do honor to those of our members who have made the supreme sacrifice on the field of battle, by standing for a moment with bowed heads in their memory."

* * *

COUNCIL AND COMMITTEE MEETINGS

September 29, 1943—Executive Committee of the Council—Lansing

October 27, 1943—Committee on Procurement and Assignment Service—Detroit

November 4, 1943—Executive Committee of The Council—Lansing

November 16, 1943—Joint Committee, MSMS and UAW-CIO—Detroit

November 23, 1943—Postgraduate Medical Education Committee—Detroit

November 23, 1943—Postgraduate Extension Committee—Detroit

December 5, 1943—Committee on Scientific Work—Detroit

December 16, 1943—Executive Committee of the Council—Detroit

December 16, 1943—Committee on Procurement and Assignment Service—Detroit

December 19, 1943—Joint Committee, MSMS and State Bar, on Venereal Disease Control—Lansing

December 19, 1943—MSMS Venereal Disease Control Committee—Lansing

January 28-29, 1943—The Council, Annual Meeting—Detroit

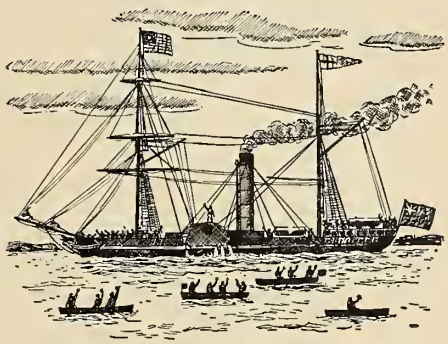
January 30, 1943—County Secretaries' Conference—Detroit

* * *

COVER ILLUSTRATION

The cover demonstrates how doctors of medicine of a portable hospital work. The hospital is located somewhere in New Guinea. This is a Signal Corps Photo, released for publication by the Bureau of Public Relations, War Department.

The Ship is different today...

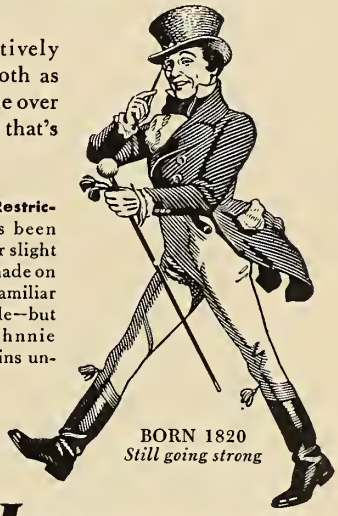


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Sunday, January 30, 1944
10:00 a.m. to 4:30 p.m.
(Eastern Standard Time)
Book-Cadillac Hotel
Detroit, Michigan

Presiding Chairman
C. L. Grant, M.D., Manistee, Michigan
Chairman of County Society Secretaries

MORNING MEETING
Crystal Ballroom
(4th floor)

I. Trends in Regimentation of Medicine

1. Federal Legislation
   J. W. HOLLOWAY, JR., Chicago, Illinois, Director, Bureau of Legal Medicine and Legislation, AMA
2. Program of Obstetric-Pediatric Care for Servicemen's Wives
   L. FERNALD FOSTER, M.D., Bay City, Secretary, Bay County and Michigan State Medical Societies
3. The Wagner-Murray-Dingell Bills
   R. L. NOVY, M.D., Detroit, President, Michigan Medical Service
4. Government Questionnaires
   WM. J. BURNS, Lansing, Executive Secretary, Michigan State Medical Society

II. Need for Public Relations

EDWARD J. MC CORMICK, M.D., Toledo, Ohio, Member of Council on Medical Service and Public Relations, AMA

NOON MEETING
Italian Garden
(4th floor)
Sunday Dinner

Committee Reports

III. Bureaucracy as It Affects Medicine

FLOYD E. ARMSTRONG, Cambridge, Mass., Professor of Economics, Massachusetts Institute of Technology

AFTERNOON MEETING
Crystal Ballroom
(4th floor)

IV. Information to the Public

1. What to Present
   T. A. HENDRICKS, Indianapolis, Indiana, Secretary, Indiana State Medical Association
2. How to Present It
   PAUL D. BAGWELL, East Lansing, Head of Speech Department, Michigan State College

V. Discussion

Led by: G. LOMBARD KELLY, M.D., Chicago, Illinois, Secretary, Council on Medical Service and Public Relations, AMA

Say you saw it in the Journal of the Michigan State Medical Society

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

THE MIND OF THE INJURED MAN. By Joseph L. Fetterman, M.A., M.D., Assistant Clinical Professor of Nervous Diseases, Western Reserve University School of Medicine, Cleveland, Ohio. 28 illustrations. Chicago: Industrial Medicine Book Company, 1943. Price $4.00.

An accident has its effect on the nervous system of the individual. It may be only minor or negligible shock, or it may be profound injury and damage to the delicate nerve tissue. Doctor Fetterman tells of the necessity of a most elaborate and painstaking history when there is question of nerve of mental damage due to injury. It may be a long delayed affair, or there may be some contributory influence working. Syphilis and its effect in parents may complicate some fine diagnosis and analysis of injury. History taking, examination and tests are carefully given. Epilepsy and post concussion changes are explained. Psychoses are mental illnesses that used to be called insanities. These symptoms must be studied with reference to trauma as a direct cause, a contributory factor, or a factor blamed for mental illness, but only a coincidence. Paresis, tumors, infections and degenerative processes, and loss of special senses are all extensively described. Personality, the problem of rehabilitation, and handling of the neuroses are given consideration. The book finishes with a chapter on medico-legal considerations. It is a valuable handbook with many hints and valuable ideas for the doctor coming in contact with the individual suffering from the many strange results of numerous forms of injury.

SYNOPSIS OF TROPICAL MEDICINE. By Sir Philip Manson-Bahr, C.M.G., D.S.O., M.D., F.R.C.P., Senior Physician to the Hospital for Tropical Medicine, Royal Albert Dock and Tilbury Hospitals Consulting Physician in Tropical Diseases to the Dreadnaught Seamen's Hospital, London, etc. With five plates. Baltimore: The Williams and Wilkins Company, 1943. $2.50.

This is not a textbook of tropical medicine, but is a synopsis in convenient form for ready reference, condensed for the use of medical officers in the armed forces, and others who have to treat tropical diseases without full training. An illustration of the scope of the book is furnished by a sample. Cholera has a paragraph on distribution and epidemiology; etiology (Cultivation, transmission, carriers, and immunity), Pathology, Clinical features, (varieties, sequelae, mortality); Diagnosis (bacteriological and differential); Treatment (over a page of suggestions, kaolin, morphia, essential oils, intravenous salines, routine treatment with potassium permanganate, supression of urine, stage of reaction, prophylaxis, prophylactic inoculation and personal prophylaxis. The book is condensed into 225 pages well indexed. It has illustrations of the various parasites.

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LIFE IS TOO SHORT. An Autobiography. By C. Kay-Scott (Frederick Creighton Wellman). Philadelphia: J. B. Lippincott Company, 1943. Price $3.50.

An autobiography is inclined to be tiresome unless by an exceptional person, and done in an exceptional manner, but here is an entertaining book telling in the first person of the life of a man of unusual attainments who led not one but several lives. Dr. Frederick Creighton Wellman started out to be a doctor of medicine in one of our southwestern states, but soon secured an appointment as medical missionary to central Africa where he took his young wife and child. He established a hospital, studied tropical diseases and for nine years built not only his mission, but himself into a tower of strength. He then went to Europe, and affiliated with learned societies, writing and studying tropical medicine. He made his place as a biologist, then returned to America and San Francisco where he undertook research on plague, and established a school of tropical medicine, later going to Tulane and becoming Dean of the School of Tropical Medicine. After a time he resigned, assumed a new name, Cyril Kay-Scott, and went to New York to try his hand at writing. Soon he went back to Europe, then to Brazil where he was first a wanderer, but soon became auditor for the Singer Sewing Machine Company, farmer and rancher. He lost his all on the ranch, and lived by dint of his hoe for two years, completely broke. Then he essayed mining, at about the beginning of World War I, rose in that calling to superintendency, then returned to the United States where, as before he threw off all connection with his former calling and started to paint, going to Paris and establishing a studio. He gradually became an artist, was recognized as a leader, hung his paintings in salons, sold many, then returned to the United States, and to Sante Fe, where he started a school. This increased in size and became such a success that the University of Denver took it over and made him Dean of their school of fine arts, and director of the Denver Art Museum. Soon after this he found, or rather his four children by his first wife, found him. They had lost all contact when he changed his name to Kay-Scott.

This is a story of interest, well told by the author of many books, papers monographs in English, Latin, German, French, and Portuguese medical, scientific, artistic and other subjects. There was a new wife for each new phase of the man's attainments. This part of the life story is intermingled with the other occupations and helps to maintain interest.

MICROSCOPIC TECHNIQUE IN BIOLOGY AND MEDICINE. By E. V. Cowdry, Professor of Anatomy, Washington University, and Director of Research, The Barnard Free Skin and Cancer Hospital, Baltimore: The Williams & Wilkins Company, 1943. Price $4.00.

All the methods and procedures in the bacteriological and physiological investigation of problems in the field of medicine are not in everyday use, and would not be immediately available to the investigator, but this book

(Continued on Page 92)

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(Continued from Page 90)

classifies them in an index which uses the name, the method or the workers name as the index word. The whole is arranged alphabetically, and under each heading is a sufficiently complete description of the process or formula. The introductory pages discuss choice of methods, depending on the type of information to be obtained, study of deviations from the normal, measurements, organization of the laboratory, and standardization of stains. Then follows 190 pages of encyclopedic material. The items mentioned and explained are very inclusive.

A SURGEON'S WORLD. An Autobiography, By Max Thorek, M.D. Philadelphia: J. P. Lippincott Company, 1943. Price $3.75.

A young boy from Budapest came with his family to Chicago. They were very poor and found an education a matter of working for everything. But that did not dismay Max Thorek. He finished Rush Medical School and located in the stockyards district. Years of struggle and study at every opportunity were followed by increased opportunities, and finally a chance to help establish the American Hospital. The story of his life before and after coming to America, of his wonderful wife and her contribution to his success, of his attempting new things, of his leadership in many kinds of research, of his successes, of his friends, is a story of absorbing interest and is well told. Success and tragedy, fortune and famine, all go to make the man, and the story is an inspiration. Every aspiring surgeon should read it.

TEXTBOOK OF PHYSIOLOGY. By William D. Zoethout, Ph. D. Professor of Physiology in the Chicago College of Dental Surgery (Loyola University and W. W. Tuttle, Ph. D. Professor of Physiology, College of Medicine, State University of Iowa. Eighth Edition. With 308 text illustrations and 3 color plates. St. Louis: The C. V. Mosby Company, 1943. Price $4.75.

The study of physiology has advanced so rapidly that new editions are needed to keep up to date. This volume has to a considerable extent been rewritten, (at least sufficient parts) to keep up on blood banks and blood plasma, hypertension, the level of blood pressure in school children and adults. While discussing foods a very good course in organic chemistry is given showing the various forms of the organic molecule, and its relationship to the body building. Vitamins are given a sufficient description, with a listing of the various systems of names. The chapters on the physiology of the special senses are especially good and deserving of study. The book is valuable, and not too big to be a burden.

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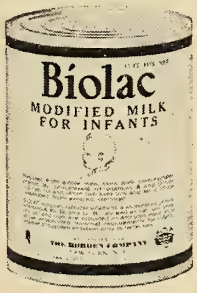
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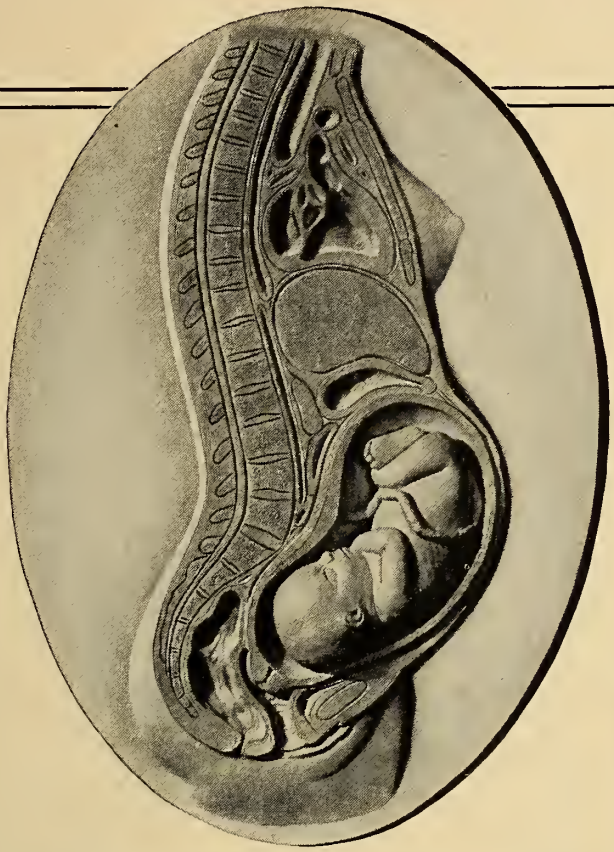
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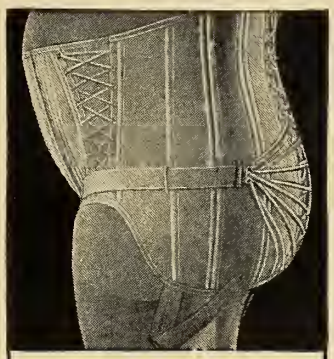
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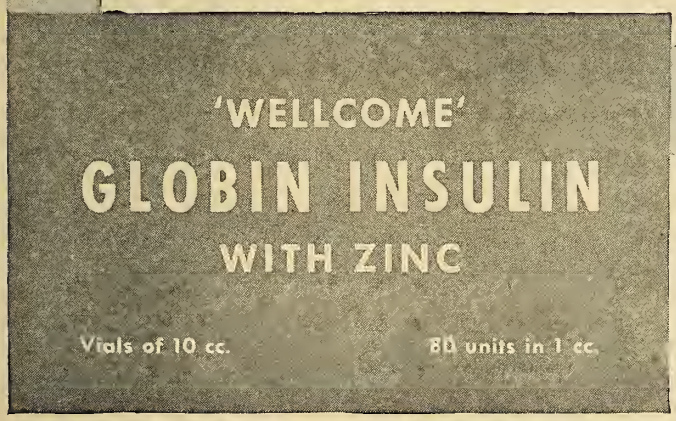
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POLITICAL MEDICINE

The Multiple Cost of Social Security*

No one business or industry can, or should, stand in the way of the welfare of the whole people. If compulsory insurance is a good thing for the American people, it would be just as foolish for private insurance to oppose its development as it would be for employers and labor to oppose the use of labor-saving machines.

"What is it going to cost?" While Sir William Beveridge does make a very detailed estimate of the cost of his program in England, our own social planners dismiss the question of cost with a mere wave of the hand.

We have no estimate of the cost of the proposed social security plan for this country. The Social Security Board has a Bureau of Research and Statistics employing 120 people and costing $258,000 in salaries and traveling expenses during the last fiscal year, but if they have issued any detailed discussion of costs such as was prepared by the Actuary of the British Government as a part of the Beveridge Plan, it has not come to my attention.

The Beveridge Plan provides for a mere subsistence level of benefits. It has been estimated by very competent research men that a similar proposal giving a subsistence level of benefits would cost the United States approximately 15 billion dollars per year.

The Wagner Bill assumes 3 per cent for medical and hospital care, and 5 per cent for unemployment and disability benefits. Both of these assumptions I believe to be too low. But in any event, the minimum cost when the program is in full operation would be 20 per cent of payrolls of employes and self-employed up to $3,000 per year.

If we embark on a social insurance scheme, the cost of which proves to be too great for our national economy to sustain, just one of two things will happen—either the actual benefits will be reduced by an inflation which reduces the purchasing power of the dollar with all of its attendant evils, or, as is more probable, the failure of free enterprise to give full employment and to sustain the social security burden will result in a demand that the government take over more and more of the functions now performed by private enterprise until we have a completely socialized economy.

But the cost will not be entirely economic. It is even more difficult to estimate the social costs. What will be the effect upon the character and the enterprise of a generation which knows that from before its birth in a government hospital, until it is laid away in the grave, a benevolent governmental bureau will pay the costs of being born, the costs of its education, will supply its recreational needs, will furnish medical services and hospitalization in illness, provide an income during unemployment and sickness, and a pension if permanently disabled or retired by old age?

Compulsory social insurance will also have its political costs. The Wagner Bill would empower the Social Security Board to take over the state unemployment agencies, to put on a system of benefits for total and permanent disability, temporary disability and hospital and medical care. This would necessitate a federal bureau with representatives in every city, village and hamlet in the country who would go into every city and farm home. I do not need to point out the political implications of such a bureau upon the tender ministrations of which every individual would at one time or another during his lifetime be dependent.

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Arthur H. Vandenberg (Grand Rapids)
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15th District	John D. Dingell (Detroit)
16th District	John Lesinski (Dearborn)
17th District	Geo. A. Dondero (Royal Oak)

This issue must be decided by the people—the voters of the United States. Show this to your neighbor. Talk to him about it. Request him to talk or write to your U. S. Senators and Congressmen.

*Extracts from address of Mr. C. O. Pauley, President, Insurance Economics Society of America.



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MICHIGAN MEDICAL SERVICE

The annual meeting of the members of the Corporation of Michigan Medical Service was called to order by R. L. Novy, M.D., President, at 2:45 p.m., Tuesday, September 21, 1943, in the Ballroom of the Hotel Statler, Detroit, Michigan. Seventy-eight members were present in person and by proxy.

Report of President—R. L. Novy, M.D.

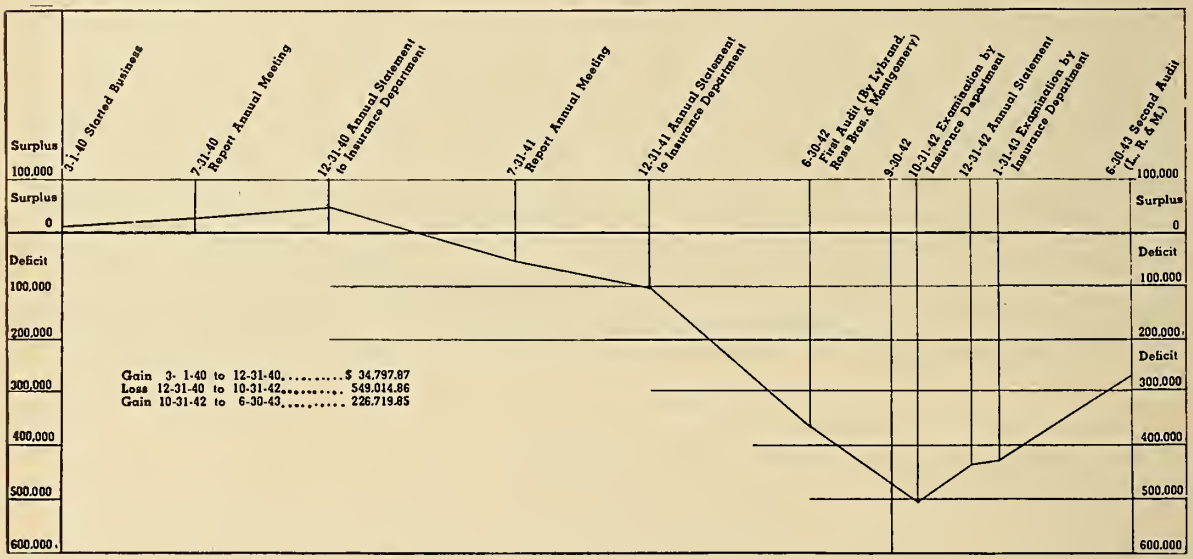
At this meeting we will attempt to review some of the things that have been done since the annual meeting of September, 1942. Recently there has been mailed to all of the members of Michigan Medical Service a copy of the certified audit as of June 30, 1943, which was completed the last of August. Accompanying the audit report was a statement of some of the accomplishments of Michigan Medical Service during the year's period. If the members have read those comments, they hardly need repetition; but we do, however, want to call your attention briefly to the situation as it exists at present.

A year ago the operation of the company was resulting in a very rapid accumulation of a deficit. The establishment of proper rates was just getting under way, and revisions in the form of the subscriber contract were just being instituted. Other problems such as personnel and the administration, et cetera, were yet to be taken care of. We have now gone through all of these phases, and certain charts that we have here, we believe, will demonstrate our success in dealing with these problems.

Chart A reflects the financial story of the corporation since inception March 1, 1940, to June 30, 1943—the date of the audit. You will note that during the first year to the end of 1940 we showed small gains of $34,797.87, which was mostly as the result of the Ford contract which was in effect during this period. Early in 1941, at which time the Ford contract was cancelled, the operation of the corporation reversed its trend and from that time until the time of our annual meeting last year losses were experienced at a rapidly increasing rate totaling $549,014.86, which wiped out our previous gains of $34,000 and left a deficit on October 31, 1942, of approximately $500,000.

This was immediately after the annual meeting of September, 1942, at which time and immediately thereafter, many of the changes in methods and procedures were instituted which resulted in an immediate improvement which has been continuous until this time showing gains each month totaling for the period $226,719.85, leaving the corporation at June 30, 1943, with a remaining deficit of approximately $275,000.

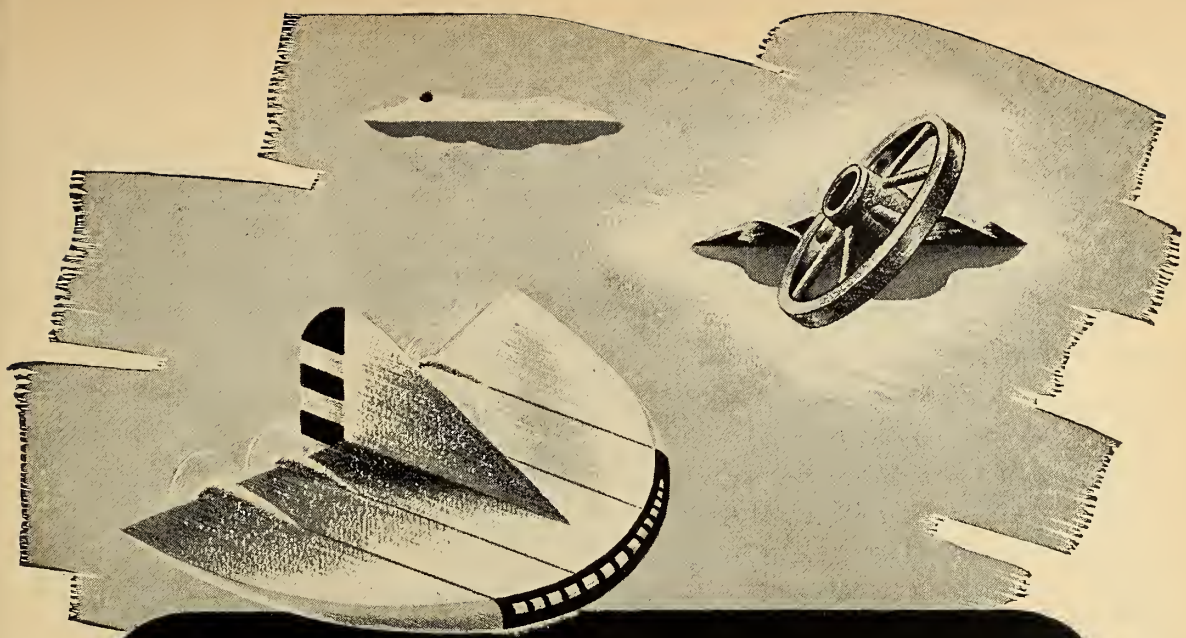
CHART A. STATEMENT OF SURPLUS OR DEFICIT AS REFLECTED IN OFFICIAL STATEMENTS



This chart shows in chronological order the various dates at which statements or audits were made. All of the figures are verified either by the annual statement, Insurance Department examinations, or independent audits.

Chart B in another manner shows somewhat the same thing. In the first column, 1940, an average monthly gain of $3,427.72 is shown, which is represented by the space between the dotted line representing income and the bottom solid line representing expenses. In 1941, after the loss of the Ford contract, the average monthly loss of $12,368.14 was experienced, represented by the diagonally scored space between the dotted line representing income and the solid line representing expenses. In 1942, for the first ten months, the average

(*Continued on Page 110*)



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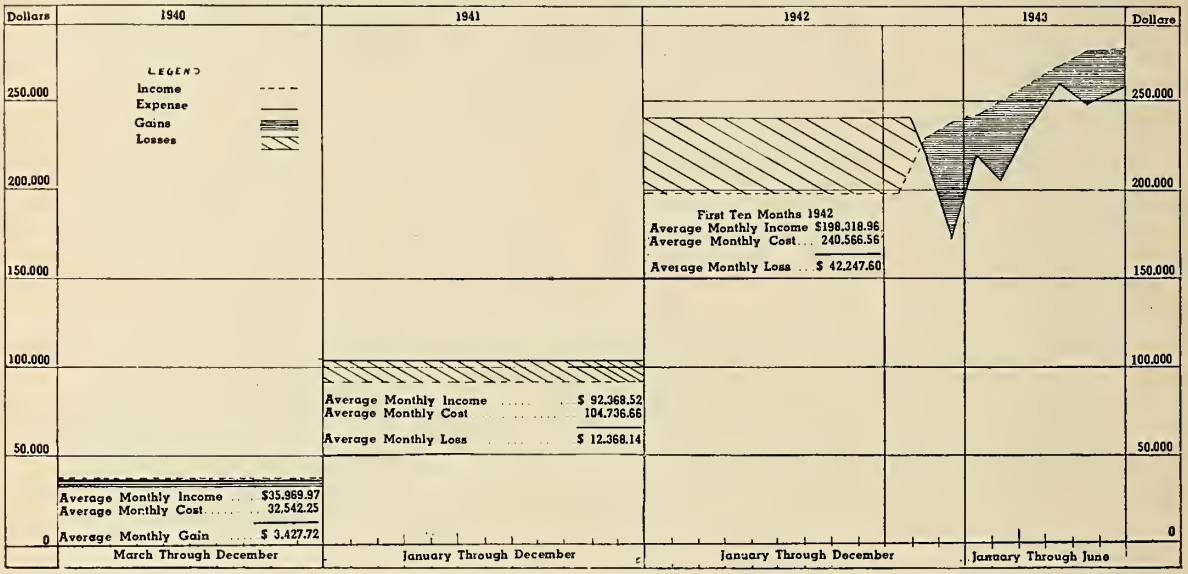
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(*Continued from Page 108*)

monthly loss of $42,427.60 was experienced as indicated by the diagonally scored space between the dotted line representing income and the solid line representing expenses.

CHART B. INCOME AND EXPENSES (SERVICES AND ADMINISTRATIVE EXPENSE)—GAINS AND LOSSES



You will recall that changes in rates and various provisions of the subscriber contract were in effect as of November 1, 1942 on practically all of the exposure then in force. The chart shows, beginning that date, gains consistently for every month since November, 1942, to the present June 30, 1943.

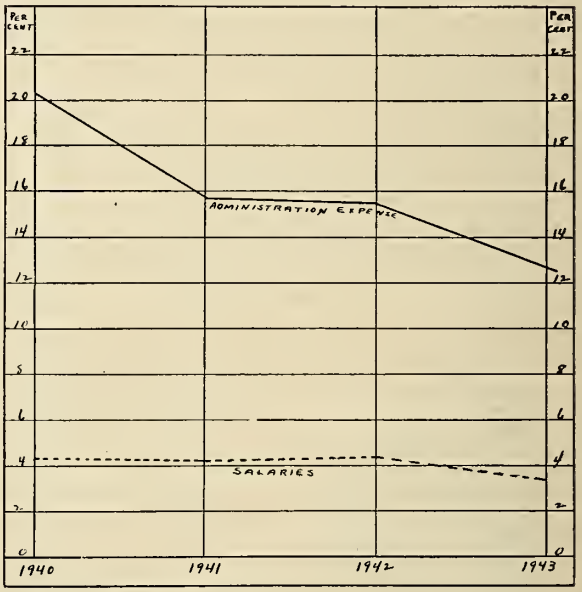
Chart C is a comparison of administration expenses and salaries to income, which shows, despite the fact that we have many more subscribers, the administration expenses in the period from 1940-1943 have decreased consistently and are still on the decline. Salaries, with the exception of a very slight rise during 1942, and particularly since January, 1943, have likewise declined. This in spite of considerably increased salary base rates and a very difficult labor market due to war conditions.

Some of the improvements which are not presented by charts were noted on the statement of accomplishments which was forwarded to you such as increase in subscription rates from a basic 50 cents for the individual subscriber to 60 cents for the individual subscriber; and collection of subscription rates in advance of month in which they are earned as opposed to the previous practice of collection during or after the month in which rates are earned.

Another problem which has been considerably clarified and simplified is the relationship of medical service to hospital service and the arrangements between them for presentation of the plans to subscribers. Our contract with hospital service has been drastically revised, providing a considerably improved method of controlling presentation and resulting in lower operating costs.

The report of services required from the physician has been greatly simplified in form. The previously required Initial Service Report has been discontinued,

CHART C. COMPARISON OF ADMINISTRATION EXPENSE AND SALARIES WITH INCOME



eliminating about fifty per cent of the paper work required of the physician rendering services to our subscribers.

The schedule of benefits has been printed and distributed so that each physician will be able to determine

(*Continued on Page 112*)

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(*Continued from Page 110*)

within reason the schedule of benefits provided under Michigan Medical Service.

Officer procedures have been revised materially to eliminate all unnecessary motion and red tape. Field representatives have been appointed to handle on the ground complaints arising in regard to subscribers' services, both with the physicians and with the subscribers.

Underwriting methods have been extensively studied and considerable change in the requirements to be met by groups has been instituted in an effort toward a sound financing of the program. There is maintained in the office at this time a complete record of each and every group with which Michigan Medical Service has dealings so that the experience of the group may be obtained at any time.

It has become the standard practice and policy of the corporation to obtain an independent audit of the corporation's affairs at least once each year. The copy which was forwarded to you recently was the second such report, the first having been made as of June 30, 1942, which was the first such audit that the corporation had ever had.

Mr. Fletcher, who is Chairman of the Finance Committee, has been of considerable assistance in arranging for these audits. He is a certified public accountant, and his help has been invaluable in this connection.

The Board of Directors, originally thirty-five, was unwieldly because of the large number, and great difficulty was experienced in getting a quorum for meetings. An effort has been made to reduce that number, which is now twenty-four. It is contemplated that the number of Directors will remain at that as a minimum, at least for some time.

Another chart of interest to physicians (*Chart D*) reflects the length of time it has taken during the past years for the issuance of checks for services rendered by physicians to subscribers of Michigan Medical Service. You will note that a year ago, in July, 1942, thirty-four days were required in which to verify the services reported and issue the check to the physician in payment. In November, 1942, the amount of time had increased to sixty days. However, the revision of office procedures and routine which was previously mentioned has resulted in a consistently declining number of days required for payment, until now, July, 1943, the average report of services is verified and check issued for the services within thirteen days. Studies made in the office of Michigan Medical Service indicate that the great delay at the present time between the date of service and date of payment is occasioned by the delay on the part of the physician in submitting his report of services to the office.

CHART D. AVERAGE ELAPSED TIME BETWEEN RECEIPT OF REPORT AND MAILING OF CHECK
JULY, 1942, TO JULY, 1943



All of the above represents a great deal of work that has been done by the Executive Committee and the Board of Directors. They have spent a good many hours on these matters and, we believe, have accomplished some real results in the way of getting things straightened out.

I am going to ask Mr. Ketchum to make some remarks at this point; and we will welcome any questions that may be asked regarding the affairs of Michigan Medical Service.

(*Continued on Page 114*)



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(Continued from Page 112)

Report of Executive Vice President—Jay C. Ketchum

It is going to be a little difficult to say anything that has not been reported to you by Dr. Novy or included in the material mailed you. I have just a few comments—highlights—to run over which may be interesting and instructive.

The income of Michigan Medical Service has increased from an average of $192,000 to $239,000 monthly. That represents an increase in the amount of dollars of 23.8 per cent over last year based on the audit; these are the auditor's figures. The expense of operation related to subscriber income has been reduced from 15.2 to 13.8 per cent which is a reduction of 9 per cent in the ratio of expenses. Our cash position has been improved in spite of a decrease in reserve for outstanding claims. Since June 30, 1943, our cash balance has raised to $200,000, which permitted us at the beginning of this month to invest $25,000 in war bonds.

Dr. Novy mentioned that office procedures have been revised materially. In the statement of accomplishments the statement was made that a year ago we had in the office eighty-one employes; we now have fifty-four. However, they are working forty-seven and a half hours a week so that each employe produces more results. However, the reduction represents a much greater reduction in personnel than the increase in hours alone would contribute. We have attempted to get a higher type employe and pay more money—more base salary—to get their loyalty and real endeavor in our office. I think we have been extremely successful in that. We have thirty employes who have been with us over a year. We have several youngsters sixteen and seventeen on work papers working either part or full time who are bright, intelligent, and who should develop into valuable workers for MMS. As you understand, for the seven and a half hours in excess of the basic forty, we have to pay time and a half. In spite of this and an almost impossible labor market, we are getting 28.3 per cent more work with fifty-four emloyes as compared to eighty-one a year ago.

You will note that the figures we have given on Michigan Medical Service's financial condition indicate continuous improvement, which is somewhat due to the increase in rates, which was 10 cents effective on most accounts as of November 1, 1942, but there are also other factors.

As Dr. Novy mentioned, we have instituted common sense underwriting requirements. We think they have eliminated considerable difficulty with individual groups —made profitable ones out of the unprofitable. Out of the larger groups in our office—those which have 15,000 or more subscribers—we have only one group that is still operating at a loss and that should be corrected within the next thirty or sixty days. The other smaller groups as a whole are showing a profit for the first time since we have been in business. The individuals—those who are not enrolled as individuals but who are transferred as they leave groups—are showing a profit for the first time.

In addition to these factors, the fact that most of these groups have been enrolled in excess of a year has quite an effect. There is definitely a seasoning or aging of the groups which is beneficial. It is impossible to evaluate that in dollars and cents; however, it is of some value. We have taken care of most of the elective surgery in these older groups and are down now to the more normal experience.

About all I have to say in addition to that is that with this increased income, the more stringent attention to underwriting and seasoning, I see no reason—and I'm going to stick my neck out again—why, at our next annual meeting, we should not be able to report that we are in the clear and have something in reserve for future contingencies.

Dr. Novy then called on Mr. Fletcher to make some comments regarding the financial affairs of Michigan Medical Service.

Comments by Chairman of Finance Committee—E. H. Fletcher

The audit for both of the years was made by a national firm of certified public accountants—Lybrand, Ross Bros. & Montgomery. You have all received a copy of that report, which alone shows a deficit on June 30, 1943, of $277,000 as compared with a deficit of $360,000 of a year ago. However, the improvement is much better than that indicates, due to the fact that the loss of operation continued from June until some time in September.

It certainly has been a pleasure to work on the Board. Up until about seven or eight months ago our meetings lasted usually until 1:00, 2:00, and 3:00 in the morning, and the meeting was always a signal to engage a room at the Statler. But lately they have been quite reasonable and have adjourned somewhere before the midnight hour.

I doubt if any of the members realize the tremendous amount of work involved in the operation of a service of this type. If anyone was interested and would go through the office and see the tremendous amount of detail necessary where 500,000 or 600,000 subscribers are involved, they would be very much impressed.

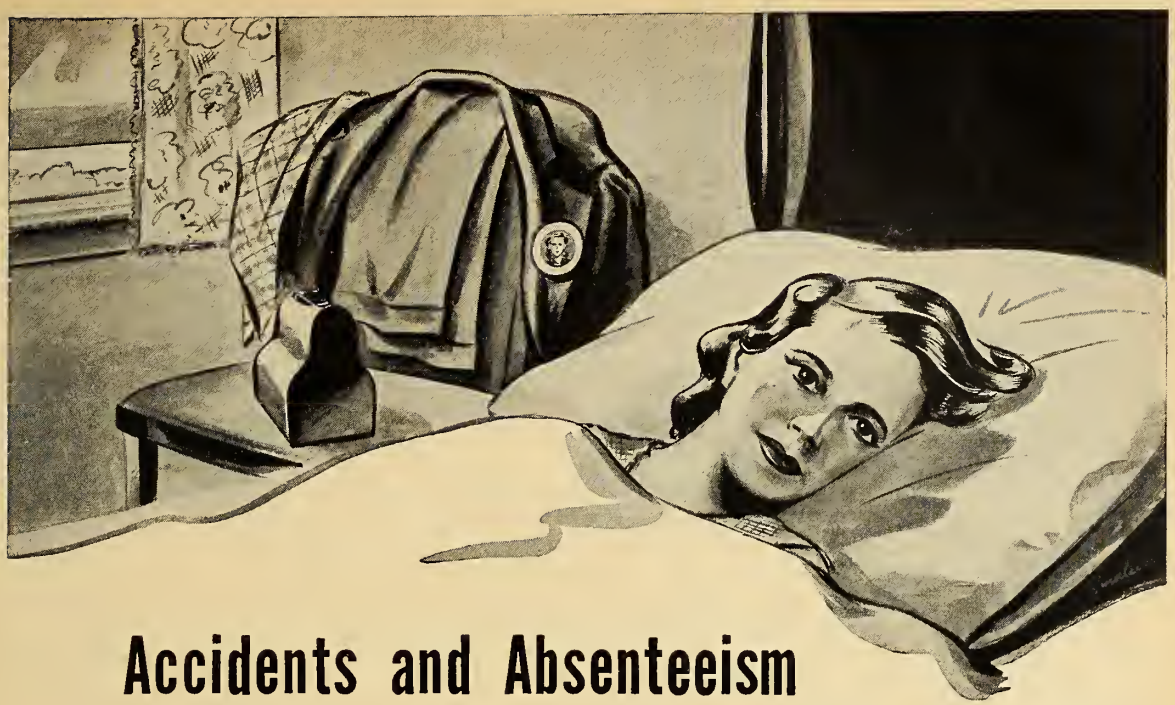
I think the administration needs to be congratulated in that they have reduced the administrative expenses during the time when the volume of business has increased very much. Now it is down to 12 per cent. I doubt if it will get any lower especially considering the fact that salaries will have to be increased.

I do not know of any other matter that I have to comment on, but I would be glad to answer any questions.

Additional Comments by President Novy

At the last meeting there were some problems brought up at this meeting and at the last meeting of the House of Delegates. I believe each and every one of these problems has been met and taken care of. I have a list of those problems that were brought up. If there

(Continued on Page 116)



Accidents and Absenteeism

ACCIDENTS contribute to absenteeism. In women — particularly the conscientious middle-aged who try to stay on the job—the nervous symptoms associated with the menopause may directly affect their efficiency, and contribute to accidents of one kind or another.

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KEEP ON BUYING MORE WAR BONDS

(Continued from Page 114)

are any questions about any one of them, I will answer them. But they have each and every one been properly met.

I will call to your attention one thing. At the present we still have a deficit to retire. It is true that we believe that our progress and improvement is going to continue and, as Mr. Ketchum said, we have every reason to believe that a year from now we will be in the clear. I will be satisfied if we break even. Things look very encouraging.

I want to call your attention to one thing, though. Anything that is done by the corporation at the present time that will in any way jeopardize the improvement that we are showing is going to meet with resistance. That is to say, no radical changes can be made at the present time without jeopardizing the possibility of this improvement. Should those changes be recommended or desired, they can wait until we are out of the red and then may be accomplished. To put them in at the present time would jeopardize the future.

Election of Directors—President Novy

The next item on the order of business is the nomination and election of Directors. A list of nominations has been made by the Board of Directors as follows:

*Doctors of Medicine*s A. S. Brunk, M.D., E. I. Carr, M.D., Wilfrid Haughey, M.D., H. H. Cummings, M.D., Clarence E. Toshach, M.D., Claude R. Keyport, M.D., A. E. Catherwood, M.D., E. R. Witwer, M.D., H.B. Loughery, M.D.

Lay Men: E. H. Fletcher, Wm. J. Norton, N. Earl Pinney.

Hospital Representatives: E. F. Collins, M.D., and L. S. Woodworth, M.D.

Other nominations, as you have been informed by Dr. Ledwidge in the meeting of the House of Delegates last evening, may be made. (No other nominations received.)

Eight Directors are to be elected from those nominated, one of which must be a Michigan Hospital Association nominee—either Dr. Collins or Woodworth—and of the balance of the nominees, at least four must be doctors of medicine in order to maintain the balance of medical profession representation on the Board of Directors as required by the Articles and By-Laws.

(Ballots were distributed. Dr. Novy appointed as Proxy Committee Dr. Stanley W. Insley and Dr. Philip Riley; and as tellers Dr. P. L. Ledwidge; Dr. W. B. Harm; Dr. O. D. Stryker; Dr. Robert Baker; and Dr. Vernor Moore. Tellers collected the ballots and retired to tally the vote.)

While the tellers are counting the ballots, we will proceed with the next item in the order of business, which is new business. Is there anything to come before the corporation? (No new business.)

I wish to make an announcement that I believe is self-evident in regard to the way we are trying to run things in Michigan Medical Service. If there is any question about any of the items discussed here today, any accounts, or otherwise with Michigan Medical Service, we invite you to visit our office down the street two or three blocks personally to inquire and settle any question you may have in your mind about any particular problem.

The tellers reported the vote with the following elected to the Board of Directors for the three-year term expiring September, 1946:

A. S. Brunk, M.D., E. I. Carr, M.D., Wilfrid Haughey, M.D., H. H. Cummings, M.D., Claude R. Keyport, M.D., E. H. Fletcher, Wm. J. Norton, E. F. Collins, M.D.

There being no further business, the meeting was adjourned.

* * *

MICHIGAN MEDICAL SERVICE

Financial Statement

October 31, 1943

ASSETS

Bonds—U. S. Government	$ 25,000.00
Cash on Hand and in Banks	157,594.66
Subscription Fees Receivable	81,594.65
Accounts Receivable	2,019.34
	$266,208.65

LIABILITIES

Reserve for Payments to Doctors for Services Rendered Subscribers:	
Reported but not Paid	$120,813.59
Unreported (estimate)	260,000.00
Reserves for Unearned Subscription Fees and Fees Paid in Advance	132,156.52
Accounts Payable	9,160.96
	$522,131.07
Deficit	$255,922.42
	$266,208.65

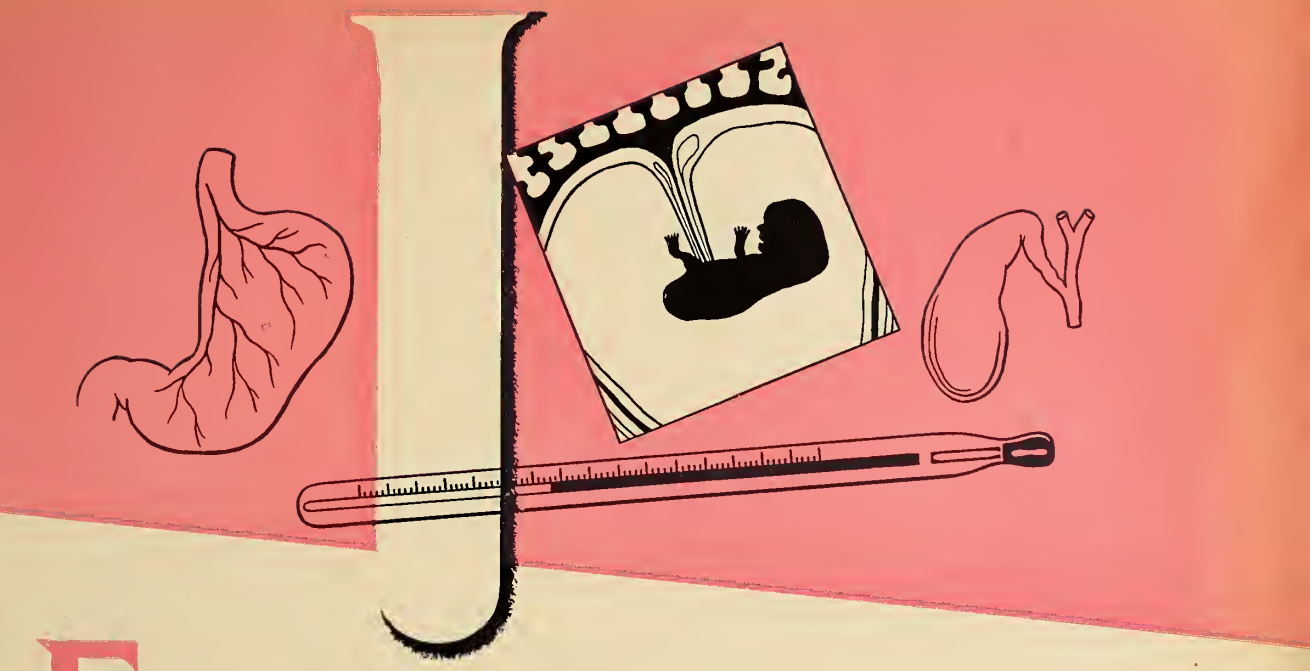
Despite the great number of services rendered during the summer months (the largest number for any similar period since inception of the corporation), there has been an improvement in financial condition, the deficit being reduced from $277,497.14 as of June 30, 1943 to $255,922.42 as of October 31, 1943 or a gain of $21,574.72 for the four-month period compared with a loss of $143,336.28 for the same four months in 1942.

IT'S DUE THE SOLDIERS

Dr. John H. Musser, of Tulane University Medical School, declares that there has been too much indiscriminate recruiting of medical men without due regard for the civilian needs, and that the Army hasn't utilized its doctors properly.

One's first impulse might be to say, "Better that way than the other." Yet what Dr. Musser, a member of a committee chosen by Secretary Stimson to get facts about medical conditions in the Army, says is important. Without being derogatory of the fine quality of the care being given men in the armed forces, he helps explain why there has been curtailment of medical care for civilians in some localities to the point of hardship and suffering.

That, where avoidable, is no more keeping faith with men in uniform than neglect or inadequate care in camp or field would be. Soldiers have a right to expect that their families and others they love will be looked after sufficiently and safely while they are away.—Editorial, *Detroit Free Press,* January 25, 1944.



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Vitamin A deficiency may be caused not only by dietary shortage, but by several factors which increase bodily needs, and/or impair the absorption or utilization of the vitamin:

severe hepatic disease which impairs the utilization of vitamin A by interfering with the conversion of carotene into vitamin A and with storage of both;

absence of bile and of dietary fat from the intestinal tract which interferes with the absorption of vitamin A;

pregnancy and lactation;

prolonged febrile and other hypermetabolic states;

diabetes mellitus.

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WAR BULLETINS

ASTP PROGRAM TO CONTINUE

The Army Specialized Training Program, which is now providing college training for thousands of Army men at more than 200 colleges throughout the nation, will be continued despite rumors to the contrary which have been circulated within recent weeks.

This information comes from Colonel S. D. Ringsdorf, commanding officer of District One, Sixth Service Command, and is based on a statement of policy received by him from the War Department. "Contrary to reports from several sources," Colonel Ringsdorf said, "the War Department has announced that the ASTP is not in the process of liquidation. The number of soldiers in the Program will depend in the future as in the past on the actual needs of the various branches of the Army."

To substantiate his statement, Colonel Ringsdorf quoted a message sent by Secretary of War Henry L. Stimson to Major General H. S. Aurand, commanding general of the Sixth Service Command. "The number of soldiers assigned for training under the ASTP," Secretary Stimson wrote, "will be changed from time to time so as to accord with the needs of the Army and available manpower. It is now being somewhat reduced but may later be increased or still further reduced as the needs of the military situation or military training make advisable."

It was pointed out that more than 140,000 men are now being trained under the ASTP. Of these 14,500 are in the Sixth Service Command area, 5,000 of them in Michigan. Wayne University's contingent, including a group being trained for the Navy, numbers almost 400.

IS THE FEDERAL SOCIAL SECURITY BOARD INTELLECTUALLY HONEST?

Few of us would ever deprecate any sincere effort by government to improve living conditions, protect public health and establish an actuarially sound cushion for old-age benefits. Surreptitious measures have been trial ballooned so often in the past eight years that we can no longer excuse the present administration of their authorship. Private enterprise, the family doctor and the small businessman are the preëminent "goats" for these architects of the new social order.

Well-established business leaders as well as physicians with many years of medical service behind them are still too skeptical of the inroads being made upon the rights of the individual. Pooh-poohing isn't enough! Word-of-mouth education of your friends, acquaintances and patients, using intelligent arguments will do more than mere damning of a social experiment.

President Roosevelt in his Budget Message to Congress on January 1, 1942, said, "I oppose the use of payroll taxes as a measure of war financing *unless* the worker is given his full money's worth in increased Social Security."

The administration apparently cares nothing for voluntary effort and private initiative because they overlook the nonprofit Blue Cross hospital service plan's success in reaching 13,000,000 employes and their families in a period of five years.

Therefore, is this a wedge for federalized medicine or a means of financing the war under the guise of a "noble experiment"?

If the broadened Social Security program is actuarially sound, honest and suitable to the needs of the American people and if the government, industry and the people can absorb the additional 12 per cent tax—there can be little argument. It is estimated that the fixed price level in 1945 is most likely to be at least 25 per cent greater than that of 1938. Most economists contend it will be higher and they all agree that the national income is not likely to go below one hundred and twenty billion with a top of one hundred and fifty billion. When we view the problem of deficit financing, change to peacetime operations and the absorption of millions of war workers into private industry, isn't it reasonable to expect the government to present a very carefully prepared and factual program which can be analyzed by impartial observers and supported by free thinking people?

If the recent tax proposal by the Treasury Department is an indication of the carelessness of administration planners, we can have little confidence in other programs proposed by pseudo-sociologists on the federal payroll. Mr. Morganthau was unable to substantiate his recommendations for increased taxes even when we discount purely political objections.

As Americans, we must admit that the greatest part of every dollar received in the Social Security fund be returned to the public in the form of benefits. Now, what have they done with money collected thus far? The Congressional Record of September 17, 1942, pages 7407-7408 relates the testimony of the Secretary of the Treasury in testifying before the House Ways and Means Committee:

"Specifically, I would suggest to Congress that it plan the financing of the old-age insurance system with a view to maintaining for use in contingencies an essential reserve amounting to not more than three times the highest prospective annual benefits in the ensuing five years."

At the end of the 1942 fiscal year the assets (reserves) of the Social Security trust fund were **three billion two hundred and twenty-seven million dollars:** the withdrawals for the same fiscal year were a measly one hundred forty-one million. Granted that there was high

(Continued on Page 120)

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(Continued from Page 118)

employment but the differential is astounding. Furthermore the receipts of the Social Security Board for this same fiscal year amounted to nine hundred seventy-two million dollars—in other words, less than 15 per cent of the payments made by employer and employe contributions during the year were returned as benefits. **Is this the "full money's worth" for the worker as requested by the President?**

And then the present administration had the colossal nerve to recommend an extension of the Social Security law as now written and asked for increased payroll taxes from the employer and the employe on January 1, 1943. Our Congress saw through this quickly enough!

The Federal government did not intend to increase benefits even though they expected this tremendous increase in income. Had the increase taken place according to the original Social Security Act, employes would have received less than 7½ cents for every dollar paid into the common fund.

HOW FAR CAN WE TRUST THE ARITHMETIC OF THE SOCIAL PLANNERS?

WHEN WILL THE PRESIDENT DENOUNCE THE SOCIAL SECURITY PROPOSAL for not complying with his recorded statement of "Full Benefits for Each Dollar"?

ISN'T THIS SITUATION CLOSELY SIMILAR TO THE POLITICAL DILEMMA OF BISMARCK IN GERMANY?

WHEN WILL OUR FEDERAL GOVERNMENT STOP CASTIGATING PRIVATE ENTERPRISE AND ATTEMPTING TO CONTROL AMERICAN MEDICINE?

ISN'T THIS WHOLE PROGRAM A THREAT TO THE OPERATION OF CHARITABLE AND COMMUNITY HOSPITALS?

Ray F. McCarthy
Blue Cross Service
Saint Louis, Missouri

BLOOD PLASMA RESERVES

Stocks of blood plasma have been sent by the state health department's Lansing laboratories to ten Michigan communities whose residents have given blood for the establishing of plasma reserves.

The plasma has been processed in the department's Lansing laboratories from blood collected during visits of a traveling clinic to Lansing, Dowagiac, Holland, Cadillac, Midland, Boyne City, Big Rapids, Manistee, Owosso and Sturgis. The operating expenses of the traveling clinic are met from a $20,000 special appropriation voted by the last legislature.

The clinic will continue to visit Michigan communities where sufficient volunteer donors are recruited by local Red Cross chapters. The Red Cross completes local arrangements, supplying additional nurse personnel, quarters, canteen service and transportation.

The stocks of plasma are apportioned among communities on the basis of units of blood supplied locally by donors. Hospitals in which reserves are maintained will furnish plasma, free of charge, to local physicians. This free distribution of plasma to physicians by the state health department will make it necessary for the patient to pay only the physician's fee for administering the transfusion.

The Lansing laboratories will maintain plasma reserves also to meet emergency needs anywhere in the state, the Office of Civilian Defense having first priority.

Plasma now being processed is in liquid form and is stored at room temperature.

WAIVERS OF PHYSICAL DEFECTS

What are the implications of waivers for known physical defects which physicians sign upon being appointed for limited service in the Army Medical Corps?

The answer to this recurrent question is clarified in a recent opinion on the subject made by the Office of the Judge Advocate General of the Army. The opinion, released by the Procurement and Assignment Service of the War Manpower Commission, is as follows:

"Response is made to your oral inquiry whether acknowledgment, on the accompanying form, of existing physical defects would preclude a person from thereafter claiming benefits to which he would otherwise be entitled on account of the service-connected aggravation of such defects. As to the defects acknowledged, the execution of such an instrument merely provides additional evidence of their existence, and to that extent would operate to preclude the person involved from thereafter claiming benefits on account of them. It is the opinion of this office, however, that the mentioned form does not purport to be a waiver of possible future benefits to which the individual might become entitled by reason of any service-connected aggravation of such defects, and would not operate to deprive the individual of any possible benefits on account of such aggravation."

SURGICAL TEAMS WORK ALL NIGHT UNDER FIRE

By TOM WOLF

(NEA Staff Correspondent)

A U. S. Field Hospital in Italy, Jan. 7—This tent city, spread over a large field which is a sea of mud, is so close to the front that our artillery is behind us. That's what they mean when they talk about "front-line medicine."

Only the most critically wounded soldiers come to a field hospital. Those who can stand the ambulance ride are sent to evacuation hospitals to the rear—in this case only 15 miles back.

Most of the casualties reach here toward evening, since it's impossible to get them off the mountains before dawn and it's a seven or eight hour trip down the mountain to the hospital.

(Continued on Page 122)



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WARTIME GRADUATE MEDICAL MEETINGS

On February 14 and on February 21 two post-graduate meetings on wartime medicine will be held at Percy Jones General Hospital, Battle Creek. These sessions are sponsored by the National Wartime Graduate Medical Meeting Committee. All members of the Michigan State Medical Society are cordially invited.

MEDICAL SECTION

February 14, 1944

Afternoon Session—4:00 p.m.

Address of Welcome—
BRIG. GENERAL J. E. BASTION, U.S.A.
Allergy Principles as Seen in Percy Jones General Hospital—MAJOR RALPH I. ALFORD, M.C.
Malaria, Its Incidence and Management—
CAPT. ROBLEY D. BATES, JR.
General Consideration of Peptic Ulcer—
CAPT. JAMES M. MACMILLAN
Some Sidelights on Soldiers with Arthritis—
MAJOR CLARENCE B. WHIMS
Inspection of Hospital

Dinner—6:00 p.m.

At adjacent hotel

Evening Session—7:30 p.m.

Presentation of Dermatological Cases—
CAPT. ALLEN W. PEPPLE
Rheumatic Fever in an Army General Hospital—
MAJOR JOHN B. MCKEE
Unusual Causes for Diarrhea—
LT. COLONEL CHARLES M. CARAVATI
Coccidioidomycosis—MAJOR WILLIAM H. WOOD, JR.
Neuropsychiatric Aspects of Fear and Its Derivatives—
LT. COL. PAUL A. PETREE

SURGICAL SECTION

February 21, 1944

Afternoon Session—4:00 p. m.

Address of Welcome—BRIG. GENERAL J. E. BASTION
Amputations— LT. COL. FRANCIS M. MCKEEVER
Prostheses— CAPT. RONALD M. BUCK
Sciatica— MAJOR FRANK H. MAYFIELD
Hospital Inspection

Dinner—6:00 p.m.

At adjacent hotel

Evening Session—7:30 p.m.

Empyema— MAJOR EARLE B. KAY
Plastic Surgery— MAJOR PRESTON C. IVERSON
Traumatic Perforations of Ear Drum—
LT. COL. CHARLES W. BARKHORN
Penicillin in Surgery— CAPT. JOSÉ M. FERRER, JR.
Pencillin in Gonorrhea— MAJOR ROSS M. NEWMAN

(Continued from Page 120)

The main tent is built like a cross. The arms and head are the three operating rooms. At the foot and middle of the cross are admission and shock tents. There are now eight patients in the shock tents lying on the litters in which they arrived.

They are still in the clothes in which they went into battle. Only the clothing immediately around the wounds has been cut off. Most of the wounds are from shrapnel or land mines.

Strung on the electric light cord which runs the length of the shock tent are bottles of plasma and blood. Life from civilian donors at home is pouring into soldiers whose own life has almost ebbed away. The whole blood comes from soldier donors here. The patients must wait in the shock tent until they gain enough strength for an operation.

Back in the surgery, three operating teams are getting ready. Instruments are boiled in a huge pot on a G. I. stove. All water for this hospital has to be brought several miles in five-gallon jugs.

In each of the three surgery tents, a field operating table stands in the center and is supported on boards to keep it from sinking into the soggy ground. The tents leak a little where they are joined, and mud is inevitably tracked in.

Down the center of each surgery are strung lights powered by a portable generator. You can find your way to surgery on a dark night by listening to the generator's humming. The operating lamps are makeshifts. Portable lights and even flashlights often have to be used during operations. Oxygen bottles are stacked around the center pole at the head of the operating table. A small coal stove at one end of the tent makes a feeble attempt to keep it warm.

Each surgical team consists of a surgeon and an assistant, an anesthetist, a nurse and two enlisted men.

They are now ready for the first of the new patients. Just as the litter bearers bring in the first man an artillery duel starts. Shells whine overhead all night.

The surgical team specializing in orthopedics and headed by Capt. William E. Ewing, Louisville, Ky., has a shrapnel casualty. Part of his jaw has been shot away. He has two holes clean through one thigh; one through the bone lower in the same leg. There's a hole clean through the other thigh, two through that leg. His arm is peppered with small shell fragments.

In the second surgery, a team led by Maj. F. W. Hall, Cape Girardeau, Mo., is patching up a groin laid open by shrapnel.

Simultaneously, in the third surgery, another team headed by Capt. Lawrence Hurt, Lexington, Ky., is removing fragments from a chest and abdomen. The operations are long—between two and three hours. Back in the shock tent, other patients are waiting. As the operations are finished, litter bearers carry the patients to a nearby ward tent. It's tricky going with a litter through the mud. One slip might undo hours of operating. The litter bearers don't slip.

Between operations, the teams slip over to the mess tent for a midnight snack. Then back to surgery. By 2 a.m., only two patients are left. Blood donors are sleeping on cots in readiness next to them. The rain and artillery have ceased. The operating goes on.

Sometimes an aid must go running to another surgery to borrow special instruments or equipment. Always it's necessary to improvise. Once toward morning the generator breaks down, and for several minutes my flashlight is the only light in one operating room.

By 4:30 a.m., the last operation is finished. It has been a short night for these teams, who sometimes have worked 90 hours without sleep. But the short night ends early; at 7 a.m., enemy shells begin dropping into a town a mile or so to the right. The patients, operated on the night before, have to be evacuated immediately.—*The Lansing State Journal,* January 7, 1944.

Table of Contents

Abnormal Uterine Bleeding After Middle Age.
Robert D. Mussey, M.D., and *Thomas R. Wilson, M.D.* 129

Congenital Heart Block.
Leslie T. Colvin, M.D., and *M. L. Lichter, M.D.* 138

An Aid in Abdominal Palpation.
Aaron A. Farbman, M.D. 141

What Price General Paresis?
William Scholten, M.D. 142

Osteogenic Sarcoma of Upper Third of Femur.
Harry C. Saltzstein, M.D. 145

Primary Atypical Pneumonias of Unknown Cause: "Virus" or "Viral" Pneumonias.
Hobart A. Reimann, M.D. 147

President's Page:
Free Enterprise in Medicine 151

Editorial:
Evolution and Bureaucracy 152
Developing a Program? 152
Cancer Manual 153
Wayne Medical Science Center 153

You and Your Business:
Declaration of Medical Policies 154
Collecting Blood for Plasma 156
1944 Postgraduate Conference on War Medicine, Technical Exhibitors 156

Michigan's Department of Health 158

Woman's Auxiliary 160

In Memoriam 162

Correspondence 164

County and Personal Activities 167

The Doctor's Library 172

Political Medicine 106

Michigan Medical Service 108

War Bulletins 118

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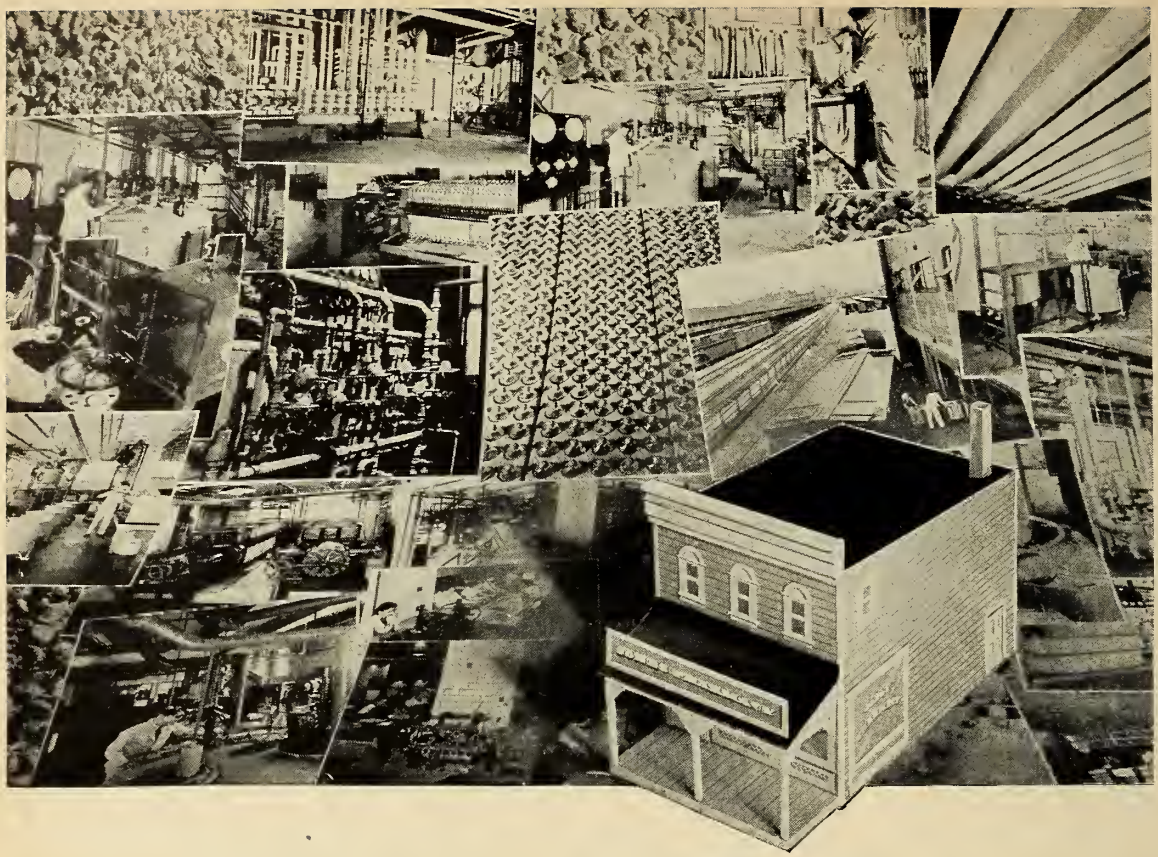
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WILLIAM JONES, PH.G.

When the doors of the Jones Pharmacy opened for business many years ago, young Mr. Jones, then just out of pharmacy school, had some definite ideas about the manner in which a prescription department should be conducted. He knew all about fresh crude drugs, and he could triturate, macerate, and percolate with the best of them. He provided sparkling glassware, and his finished prescriptions were things of beauty. He operated very successfully and the doctors liked to have him do their compounding.

Things have changed since that day when Mr. Jones opened his store. For example, along about 1923 quite a commotion was raised over something called Insulin, discovered by a couple of fellows up north. Mr. Jones immediately established an Insulin department. He was quick to realize, however, that the tons of equipment required for grinding pancreas glands and processing them through a complicated series of extractions, concentrations, and purifications had no place in his store. Mr. Jones's Insulin is manufactured in Indianapolis, miles and miles away.

The production and standardization of Iletin (Insulin, Lilly) in its various strengths and modifications is but one of the many contributions Eli Lilly and Company has made toward the improvement of Pharmacist Jones's service to the medical profession.



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Say you saw it in the Journal of the Michigan State Medical Society

The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

Volume 43 February, 1944 Number 2

Abnormal Uterine Bleeding After Middle Age

By Robert D. Mussey, M.D.
and
Thomas R. Wilson, M.D.
Rochester, Minnesota



Robert D. Mussey

Robert D. Mussey, M.D.
Head of Section on Obstetrics, The Mayo Clinic and The Mayo Foundation.

Thomas R. Wilson, M.D.
Fellow in Obstetrics and Gynecology, Mayo Foundation.

Some 200 consecutive case records of patients with abnormal uterine bleeding examined in the year 1937 were studied to determine the various causes of such bleeding and their relative incidence, and to review diagnostic criteria and methods of treatment. In so far as it is possible this subject is treated from the viewpoint of the examination and diagnosis of the ambulatory or office patient for whom one or more of various methods of treatment may be advised, such as, medical, hormonal, radiologic or surgical; results of treatment are reviewed.

▪ This paper is based on the records of 200 women who registered consecutively at the Mayo Clinic in July, August and the first portion of September, 1937 and who presented abnormal uterine bleeding as the chief complaint or as a prominent symptom. The cases were selected from the year 1937 so that the results of treatment could be reviewed after an interval of five years. Of the 200 patients, 125 had been reëxamined or had reported their condition fairly recently before this study was begun and letters of inquiry were sent to the remainder. We were interested in knowing the chief cause of the abnormal bleeding and of any associated conditions which could cause bleeding. It follows that the various diagnoses add up to more than 200. The patients were all ambulatory and represented a cross section of patients with abnormal bleeding ordinarily encountered in our practice of gynecology. Cases of pregnancy, abortion, ectopic pregnancy, and so on, were not included in this group.

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Definitions

Abnormal vaginal bleeding, menorrhagia or metrorrhagia, is one of the common presenting complaints of the patient who visits the gynecologist. If inquiry reveals that twelve to eighteen or more napkins are used in the course of a period of flow, or if the bleeding persists more than a week, it may be assumed that the patient has menorrhagia. "Metrorrhagia" is used to denote intermenstrual spotting occurring at irregular intervals; spotting of a physiologic nature occasionally occurs at about the time of ovulation and sometimes one or more days directly prior to the onset of menstruation. "Menometrorrhagia" is the term used when both menorrhagia and metrorrhagia are present.

General Diagnostic Considerations

Abnormal vaginal bleeding should be regarded with suspicion, and especially when it occurs after the patient has passed middle age. Reference to the age of thirty-five years will appear frequently in this paper. The period of life after the age of thirty-five years is an arbitrary one, of course, and is meant to include life before

and after menopause, as well as the period of the menopause. Unfortunately, many women past the age of thirty-five years and more of them who are more than forty, view abnormal bleeding as a manifestation of "change of life" and do not consult the physician for a considerable time after they have observed the bleeding. This results in many deaths which might have been avoided had the patient been more prompt to visit her physician. Due to changes in ovarian function and other physiologic endocrine disturbances which are inclined to occur near the time of menopause, abnormal vaginal bleeding may occur without implying serious organic disease. However, no patient past the age of thirty-five years, who notes abnormal uterine bleeding, especially metrorrhagia, should be dismissed until it is reasonably certain that a malignant condition does not exist. Certainly women with such symptoms should not be given any form of hormonal therapy until the physician is sure that malignant disease is absent.

Many of the causes of abnormal vaginal bleeding among women who have passed the age of thirty-five years can be discovered readily by means of thorough pelvic examination. This examination should include inspection of the urethral meatus and vaginal introitus and bimanual palpation of the cervix, uterus and adnexa. Examination of the vagina by speculum, with direct visualization of the mucous membrane and cervix never should be omitted. Direct visualization of the cervix is most important, as the cervix is one of the most frequent sites of pathologic change in the pelvis. Biopsy of any lesion which arouses suspicion should be done. Except in the presence of pregnancy, diagnostic curettage should be used in every instance in which there is doubt about the character of the uterine contents, and the curettings should be examined promptly under a microscope. Biopsy and curettage are simple surgical procedures which carry little risk and should be employed without hesitancy in case the diagnosis is in doubt.

Although this presentation deals with uterine bleeding, there are conditions or lesions of the vaginal introitus, or of the vagina, which may cause bleeding. The blood in these conditions could mistakenly be thought to be of uterine origin. Some of these conditions are ectropion of the urethral mucosa, urethral caruncle, bacterial vaginitis and senile vaginitis. These local conditions usually are obvious and readily discovered. In the series of cases on which this paper is based, senile vaginitis was diagnosed as the cause of bleeding in one case.

Arbitrarily, the conditions responsible for the bleeding recorded in this paper have been divided into several groups: benign conditions, functional conditions, malignant conditions, and postmenopausal conditions.

Benign Conditions

Benign Disease of the Cervix.—Cervicitis or erosion of the cervix, or both, occurred in forty-five cases in this series and was the only lesion present in ten cases. These conditions may cause symptoms identical with those of early carcinoma of the cervix, such as metrorrhagia, menorrhagia and "contact bleeding" after coitus or after insertion of a douche nozzle.

Treatment.—Treatment of cervicitis and cervical erosion should be undertaken as soon as these conditions are discovered, since the presence of such irritative lesions may predispose to later development of carcinoma. One of the most effective methods of treatment is electrocoagulation with a nasal-tipped electric cautery. This procedure is simple and can be done in the office under topical anesthesia with cocaine. Caustic substances occasionally are applied in lieu of the electrocautery but are relatively ineffective. When the cervix is markedly hypertrophic and infected, its amputation, conization, or deep surgical cauterization may be the treatment of choice. The cervix was cauterized in twenty-one of the forty-five instances considered here; in some of the remaining twenty-four cases, cauterization was advised or the lesion was associated with other conditions for which other treatment was advised.

Cervical polyps were found in seventeen cases, in seven of which the polyp appeared to be the sole source of bleeding. Cervical polyps are usually small, pedunculated, mucosal tumors which commonly arise within the vaginal portion of the cervix. These small polyps are frequently causes of intermenstrual or postmenopausal bleeding. Contact bleeding occurs commonly in the presence of polyps. A cervical polyp can be removed readily by torsion, or it can be cut at the

base and cauterized. Either can be done as an office procedure. If the polyps are multiple and arise from far up in the endocervix, removal is better accomplished under anesthesia and accompanied by curettage and cauterization of the base of the polyp. Several instances occur each year at the Mayo Clinic wherein polyps of innocent appearance, which routinely are examined microscopically after removal, are found to be carcinomatous. The polyps were removed in thirteen of the seventeen cases of this series and total hysterectomy was done in four cases. All of the polyps were benign. Bleeding did not recur in any of the cases.

Chronic Endometritis.—Within the memory of many physicians now living, chronic endometritis was thought to be a disease of common occurrence and a frequent cause of abnormal uterine bleeding. It has been shown, however, that chronic endometritis occurs rarely. Curtis[2] stated, "Chronic endometritis is infrequent; in fact, it rarely exists as an independent clinical entity." Boyd[1] stated, "There can be little doubt that chronic inflammation of the endometrium accounts for only a small proportion of those cases of irregular uterine hemorrhage that present no physical signs." As a matter of fact it is doubtful that "chronic endometritis" is actually an inflammation.

In the series of cases with which this paper is concerned, chronic endometritis was found eight times. Fibroid tumors were associated with this condition in four cases. In two of these four cases treatment consisted of diagnostic curettage and a menopausal dose of radium, in one, of diagnostic curettage, and in one, of total abdominal hysterectomy and salpingo-oöphorectomy. In one case of the eight, chronic endometritis was associated with subinvolution and fixed retroversion; treatment was by total abdominal hysterectomy. In another case of the eight, also associated with subinvolution, diagnostic curettage was done and a menopausal does of radium was administered. In two cases of the eight there were no findings other than chronic endometritis. In one of these two cases curettage alone was done and in the other diagnostic curettage was followed by application of a menopausal does of radium.

Menorrhagia was the predominant symptom in the eight cases, occurring six times, with menometrorrhagia occurring in the remaining two cases. In none of these eight cases of chronic endometritis had parturition recently taken place.

Chronic endometritis evidently does occur as a clinical entity, but doubtless it is rare, and cannot be diagnosed without histologic examination of the endometrium.

Endometrial Polyps.—Cervical polyps have been discussed. In this series of cases, endometrial polyps occurred in three instances, in all of which fibroid tumors were associated pathologic features. In two cases a diagnosis was made of polypoid endometrium associated with endometrial hyperplasia. None of the polyps was malignant. A menopausal dose of radium was administered in one of three cases and in two cases total abdominal hysterectomy was performed. All three patients were cured.

Benign Ovarian Cysts.—Ovarian cysts are rarely the cause of abnormal uterine bleeding unless they are of the unusual type that secrete estrogenic hormone, such as the granulosa cell tumor. In the series of cases under consideration there were four of simple ovarian cyst, in three of which the cysts were associated with fibroid tumors and, in one, with hypertrophic endometrium.

Pelvic Inflammatory Disease.—This is a fairly frequent cause of abnormal uterine bleeding among relatively young women but it becomes of progressively infrequent occurrence after the age of thirty-five years. In an analysis of 3,956 cases of abnormal vaginal bleeding, Millen and Shepard[6] found only fifty-seven instances of bleeding associated with pelvic infection among patients past the age of forty years. In our series of cases there was only one of pelvic inflammatory disease, an incidence considerably lower than usual.

Tuberculous Endometritis.—One patient, forty-eight years of age, presented herself with the complaint of menometrorrhagia. Diagnostic curettage was done and examination of the endometrium revealed tuberculous endometritis. A menopausal dose of radium was administered, following which the patient had no further pelvic sym-

toms. There was no palpable evidence of disease of the fallopian tubes and pelvic examination gave essentially negative results otherwise.

Uterine Fibromyomas.—In this series of 200 cases the most commonly occurring cause of abnormal vaginal bleeding was the presence of uterine leiomyomas or "fibroids" of the uterus. This condition was present in eighty, 40 per cent, of 200 cases. Leiomyomas were present in thirty-three cases, 16 per cent of 200 cases, without other pertinent physical or pathologic features being found. Menorrhagia was present in fifty-two cases, menometrorrhagia in twenty-four cases and metrorrhagia in four cases. Several minor conditions were associated with the uterine leiomyomas in some of these cases and are mentioned because they are sometimes the source of uterine bleeding; these were benign ovarian cysts, three cases; hypertrophic endometrium, eighteen cases; endometrial polyps, three cases; endometritis, four cases; cervical polyps, four cases; cervicitis, eight cases; atrophic endometrium, eleven cases and adenomyosis, one case.

Treatment.—The treatment of bleeding uterine leiomyomas has been fairly well standardized. If the patient is relatively young, between thirty-five and possibly forty-one or forty-two years of age, and has severe menorrhagia, probably the treatment of choice is preliminary curettage to rule out carcinoma, followed immediately by hysterectomy. Because of the advisability of preserving ovarian function at this age, hysterectomy is preferable to treatment with radium. Hysterectomy may be done vaginally whenever it is technically feasible. If abdominal hysterectomy becomes necessary, total removal of the uterus is now done more commonly than formerly, as this obviates the danger of subsequent carcinoma of the cervical stump. If the bleeding is not too severe and the tumor is not too large, medical management might be instituted following diagnostic curettage. Medical management would include hormonal therapy, iron, calcium and rest during the time of menstruation. With this type of treatment, the bleeding of some patients can be controlled until they enter the menopause, which may be followed by less flow and regression of the tumor. Certainly the mere presence of fibroid tumors even those as large as the uterus of a patient two and one-half months pregnant, does not usually require radical surgical operation unless the bleeding is metrorrhagic in type or the patient is bleeding to such an extent that the flow cannot be safely controlled by medical measures.

If the patient is say, forty-three or more years of age, a different attack can be employed. In this age group the patient, as a rule, is on the verge of the menopause or in the process of the menopause. If the mass is not larger than the uterus when gestation is at two and a half to three months, these patients commonly do very well after a menopausal dose of radium following diagnostic curettage to rule out malignancy. After treatment with 1200 to 1500 mg. hrs. of radium, ovarian function and bleeding among patients more than forty-two or forty-three years of age are not likely to recur. Then, too, in this older group, ovarian function is beginning to fail and the sudden menopause produced by irradiation is not commonly followed by the pronounced menopausal symptoms that not infrequently occur among relatively young women. Surgical operation may be indicated for many patients in this older age group, namely—those who give evidence of chronic or subacute pelvic inflammatory disease; those who have fibromyomas larger than the size of the uterus at three months of gestation; those whose fibromyomas are growing rapidly, are pedunculated, are submucous or are degenerating; those who suffer from radiophobia, and those who are suspected of harboring a malignant growth of the body of the uterus.

In the series of cases considered here, a menopausal dose of radium was given to seventeen patients who had fibromyomas. The uterine bleeding was relieved in all but two cases. In one of these two cases the patient was thirty-eight years of age and bleeding recurred ten months later, but did not require further treatment; in the second case of the two, the patient was forty-two years of age and hysterectomy was required a year later because of excessive bleeding.

Hysterectomy was performed in forty-six of the eighty cases; the hysterectomy was total in thirty-two cases, subtotal in nine cases and by the vaginal route in five cases. In twenty-five cases curettage was done, chiefly as a diagnostic procedure.

"Functional" Conditions

So-called functional bleeding is frequently encountered in premenopausal years, so commonly in fact, that laymen are likely to regard it with little concern and often neglect this very important symptom. In many instances it is caused by ovarian dysfunction which, from a practical standpoint, is diagnosed with difficulty, if at all. In the presence of persistent metrorrhagia or of menorrhagia, occurring in middle age either with or without a demonstrable accompanying pathologic condition, diagnostic curettage is practically always indicated. So commonly has microscopic examination of the curettings revealed hypertrophic or hyperplastic endometrium that this condition has been thought to be the cause of the bleeding. Hyperplastic endometrium probably is a result of dysfunction or imbalance of the ovarian hormones. Bleeding may occur in the presence of atrophic endometrium or even when the endometrium is of normal appearance.

Hyperplasia of the Endometrium.—Hyperplasia of the endometrium was the second most comon condition in the series of cases on which this paper is based. It occurred in forty-three cases, or 21 per cent of 200; it was associated with fibromyomas in eighteen cases, with uterine displacement in eleven cases and with subinvolution in five cases.

The diagnosis of hyperplastic endometrium is made chiefly from microscopic examination of curettings or of specimens obtained at biopsy. In many cases gross pathologic change is not found on pelvic examination.

The curettage which is performed chiefly for diagnostic purposes is also temporarily effective treatment in some cases in which there is no other cause for bleeding; but usually menorrhagia recurs in several months. Injections of progesterone are frequently of value, and the product should be given in doses large enough to stimulate a secretary (differentiative) phase of the endometrium. However, this treatment is seldom curative and usually must be repeated. A menopausal dose of radium may be indicated if the patient is in the premenopausal period. It is necessary occasionally to resort to hysterectomy because of uncontrollable bleeding.

In these forty-three cases in which endometrial hyperplasia was present, curettage was performed twenty-nine times; in fourteen of the twenty-nine cases it was the only treatment but in fifteen instances (in five of these fifteen fibromyomas were present) the curettage was followed by treatment with a menopausal dose of radium. Of the fourteen patients who received only curettage, ten were cured, the condition of three was improved and that of one was not improved; additional treatment was necessary in three of the fourteen cases. In three of the fifteen cases in which radium was employed, bleeding recurred but no further treatment was required.

Thus far, twenty-nine of the forty-three cases have been accounted for, which leaves another group of fourteen to be considered. In these cases, the endometrial hyperplasia was associated with uterine fibromyoma and hysterectomy was required.

Purely medical treatment of hyperplasia of the endometrium was not employed since a surgical measure, usually curettage, was necessary before the diagnosis could be made. After the diagnosis had been made, medical treatment was instituted in three cases. The treatment was hormonal in all three cases and was supplemented with calcium in one case; two patients were cured but the condition of one was not improved and further treatment was required.

Atrophy of the Endometrium.—Atrophic endometrium usually is found in association with the other physiologic changes which occur at the time of menopause. Bleeding may occur from an atrophic endometrium, or at least an atrophic endometrium may be the only finding on examination after diagnostic curettage.

In the series of cases with which this paper primarily deals, atrophic endometrium was found in twenty-five. The average age of these patients was approximately fifty years, but in none of the cases was the bleeding of postmenopausal type. Atrophic endometrium was the only finding in seven cases. It also occurred in the presence of such conditions as fibromyomas, subinvolution, uterine displacement, endometrial polyps, cervical polyps and cervicitis.

Curettage was done in twenty of the twenty-five cases. A menopausal dose of radium was used in eleven of these twenty cases, in one of which the bleeding recurred one year later and a second curettage was required. In one case

of the twenty, in which case there was no finding other than atrophic endometrium, it became necessary to perform hysterectomy because of persistent bleeding. Total abdominal hysterectomy was performed in two and vaginal hysterectomy in three of the twenty-five cases, in all five of which fibromyomas were present also.

Thyroid Dysfunction.—There were two cases of low basal metabolic rate without myxedema. In one of the two cases the basal metabolic rate was –20 per cent and in the other –23 per cent. Administration of desiccated thyroid only was used to control the bleeding in one case. In the other, diagnostic curettage revealed hypertrophic endometrium, following which the bleeding was adequately controlled with thyroid.

In one other case adenomatous goiter with hyperthyroidism was present and the basal metabolic rate was + 45 per cent. This patient also had large fibromyomas and was bleeding profusely. Subtotal thyroidectomy was done, followed later by hysterectomy.

Treatment of Functional Conditions.—Examination of the histories in the series of 200 cases shows that a large majority of the women had one or more demonstrable conditions which could, or did, account for the abnormal bleeding, so that the diagnosis of functional bleeding was relatively infrequent. In twenty-four cases the bleeding presumably was functional but, in ten cases, small fibromyomas were present; in five mild endocervicitis with erosion; in one, a lowered basal metabolic rate, and, in one each senile vaginitis, subinvolution of the uterus and uterine retroversion. In only five cases were there no pertinent findings.

So-called functional uterine bleeding is thought to be caused by endocrine dysfunction. Such dysfunction readily can be determined in cases of thyroid disease but the exact diagnosis and nature of ovarian dysfunction is not easily made and requires special endocrine laboratory equipment. Even after the results of biologic tests for prolan and estrin have been obtained and tests for pregnandiol have been made, the results frequently are not conclusive.

It follows that treatment in many such cases has been by the trial and error method. In this series various measures were employed, such as: administration of thyroid extract, calcium, iron, progesterone, estrogenic hormones or their substitutes, antuitrin S and snake venom. A few patients were treated expectantly and were advised to lessen physical activity and report later.

Ten of the twenty-four patients with functional bleeding were relieved by medical management; nine who failed to obtain relief were treated surgically; six of these were treated by hysterectomy and three by curettage, followed in two cases by menopausal doses of radium. Five patients needed additional treatment elsewhere.

Malignant Conditions

Carcinoma of the Uterine Cervix.—The cervix is the most common site of carcinoma of the female genital tract. It is usually manifested by abnormal vaginal bleeding and most frequently by bleeding between menstrual periods or after the menopause. The patient often gives a history of bleeding after coitus or after taking a douche—the so-called contact bleeding. When these symptoms occur, malignancy of the cervix must always be suspected and the appropriate examinations carried out.

In the series of 200 cases on which this paper is based, carcinoma of the cervix occurred in sixteen; the average age of the patients who had carcinoma at this site was fifty years. The predominent symptom was metrorrhagia; it occurred in ten cases. Menometrorrhagia occurred in five cases and menorrhagia only in one case. Nine of these sixteen patients presented themselves with the complaint of postmenopausal bleeding.

Of the sixteen cases, in two the carcinomas were of stage 2*; in eleven, of stage 3; and in three, of stage 4. The average duration of symptoms was twelve and a half months, varying from two to thirty-six months. The grade of malignancy was 3 in twelve cases; 4, in three cases and 2 in one case. In twelve cases the treatment employed was a combination of radium and roentgen rays; in two cases this treatment was limited owing to other complications and in two cases treatment was not given because of the advanced stage of the disease. Radium and roentgen rays is the most effective method of treatment in the majority of cases of carcinoma of the cervix. Total hysterectomy, by a

*International classification.

technique similar to Wertheim's operation, has produced results paralleling irradiation in cases of carcinoma of the cervix of stage 1. Taussig[8] has advised dissection of the pelvic lymph nodes following irradiation in many cases of cervical carcinoma.

Six of the sixteen patients (37 per cent) have remained cured for five years and, on last examination, gave no evidence of recurrence. One patient apparently was cured three years after treatment, but has not been heard from since; another, in an advanced stage of carcinoma, was not treated and has not been traced. The remainder died in a period varying from two to eighteen months, with the length of life averaging about ten and a half months.

Carcinoma of the Body of the Uterus.—Carcinoma of the body of the uterus is usually adenomatous in character and is not nearly of so frequent occurrence as is carcinoma of the cervix. Carcinoma of the uterine body accounts for only about 10 to 12 per cent of the reported cases of carcinoma of the uterus. However, in this present series, there were eleven carcinomas, all adenocarcinomas, of the corpus uteri, which represents 40 per cent of the cases of uterine carcinoma.

The predominant symptom was metrorrhagia; it occurred in eight cases of the eleven. Menometrorrhagia was present in the remaining three cases. The average age of the patients was fifty-three years. The average duration of symptoms was nine months. In ten instances, examination of tissue was made. In one instance the tissue was not examined but the case was clinically, one of adenocarcinoma. Malignancy was graded 1 in seven cases, 2 in one case and 3 in two cases.

In eight cases the malignancy was described as limited; in two cases as moderately advanced, and in one case as far advanced. In the case in which the carcinoma was far advanced, tissue was not examined; moreover, only one roentgenologic treatment was given at the clinic; the patient died seven months later.

In eight of the eleven cases the condition was postmenopausal, with the onset of bleeding occurring after at least nine months of amenorrhea. All of the eight patients were more than forty-two years of age.

The treatment of carcinoma of the fundus is primarily surgical and, not infrequently, surgical operation is followed by a course of roentgen therapy. Total abdominal hysterectomy and bilateral salpingo-oöphorectomy is the treatment commonly employed. In this series, total abdominal hysterectomy and salpingo-oöphorectomy were performed in eight cases. In two cases of the eight this was combined with roentgen therapy, and in one case, with radium and roentgen therapy. In one case of the eleven vaginal hysterectomy was performed for a very limited malignant growth; this patient was well in 1943 when this paper was written. One patient of the eleven was treated with radium and another received only one treatment with roentgen rays.

Seven of these eleven patients have been well for at least five years. Two were in good health, without evidence of spreading of the disease four years after treatment and have not been heard from since. One patient, who had a moderately advanced carcinoma, graded 3, died eight months following total abdominal hysterectomy and bilateral salpingo-oöphorectomy. One patient with far advanced carcinoma received only one roentgenologic treatment and died seven months later. These results bear out the accepted opinion that surgical treatment of carcinoma of the body of the uterus is much more effective than any method of treatment of carcinoma of the cervix.

Sarcoma of the Body of the Uterus.—Sarcoma of the uterus is a relatively rare disease and, according to Curtis, occurs in the proportion of one sarcoma to 50 carcinomas. In this series there were two cases of sarcoma of the uterus, a disproportionately large incidence.

Sarcoma of the uterus usually develops in a leiomyoma although it may arise from the uterus itself. Present methods of treatment of sarcoma are entirely inadequate.

One of the patients in this series was forty-eight years of age and symptoms had been present for eighteen months when she first came under our observation. The sarcoma was far advanced and pulmonary metastasis was present. The malignancy of the sarcoma was not graded. Uterine leiomyomas were present. The patient died five months after we saw her. The other patient was sixty-six years of age and symptoms had been present for three months. The sarcoma was far advanced. Again pulmonary metastasis was pres-

ent and treatment was not attempted. Biopsy disclosed fibrosarcoma grade 4. This patient also had uterine leiomyomas.

The treatment of sarcoma is surgical, when the extent of the growth permits. It includes removal of uterus, tubes, ovaries and pelvic lymph nodes. Surgical operation should be followed by extensive roentgen therapy.

Carcinoma of the Ovary.—This series included one case of carcinoma of the ovary. The patient was sixty-four years of age and had postmenopausal bleeding although carcinoma of the ovary does not usually cause abnormal vaginal bleeding. Approximately 20 per cent of ovarian tumors are malignant. In the case under consideration the carcinoma was a solid tumor of malignancy graded 4, which had invaded the sigmoid. It was associated with uterine leiomyomas. Total abdominal hysterectomy and salpingo-oöphorectomy were performed, with removal of lymph nodes of the sigmoid. Roentgen therapy was given postoperatively. The patient died nine months later.

Postmenopausal Conditions

In thirty cases of this series, there was postmenopausal bleeding. Bleeding was considered to be postmenopausal if the patient was more than forty years of age and amenorrhea had persisted for at least six months.

In seventeen of the thirty cases, or 57 per cent, malignant disease of the pelvic organs was present. In nine cases of the seventeen cases malignancy of the uterine body was found; in eight, adenocarcinoma and in one, fibrosarcoma. In seven cases, carcinoma of the cervix, and one case, carcinoma of the ovary was present.

In thirteen of the thirty cases, or 43 per cent, malignancy was absent. In four of the thirteen cases, cervical polyps were present; in two, cervicitis, and in one, senile vaginitis. There was no demonstrable reason for the bleeding in the remaining six cases although fibromyomas were present in one case in which no other pathologic change was found. Diagnostic curettage was done in eleven of the thirteen cases. In one of the other two cases a cervical polyp was removed and the cervix was cauterized. In the remaining case, one in which postmenopausal (senile) vaginitis was present, weak iodine douches were prescribed.

The percentage of malignancy among cases in which postmenopausal bleeding was encountered in this series is similar to that reported by other investigators. Pemberton and Lockwood[7] found benign lesions to represent 49 per cent, malignant lesions 51 per cent, among 596 patients with abnormal bleeding who were older than fifty years. Taylor and Millen[9] found malignant lesions in 63 per cent of cases in which postmenopausal bleeding occurred.

The conditions associated with benign postmenopausal bleeding need no comment as to treatment except, perhaps, senile vaginitis. This condition is not of uncommon occurrence and is characterized by atrophy of the vaginal mucous membrane, associated with dryness and parchment-like consistency. Frequently breaks in the continuity of the mucosa appear with the resultant bleeding. This is best treated by administration of estrogenic suppositories, rather than by giving estrogenic substances by mouth or by injection, since there is always the possibility of producing uterine bleeding when the estrogenic medication is stopped.

Comment

Besides the old standbys among conservative methods of treatment, such as administration of thyroid, calcium, iron, ergotrate, bed rest, and so on, more effective methods of conservative treatment for functional uterine bleeding have been developed in recent years.

Hamblen and associates[3,4] have shown that functional bleeding can be controlled by giving cyclic injections of stilbestrol or natural estrogens and progesterone, to correspond somewhat with the natural balance between estrogen and progesterone. Bleeding also can be controlled occasionally by administering enough progesterone to produce a secretory endometrium. Chorionic gonadotropin has been administered with the same idea in mind, to obtain a secretory endometrium, since most functional bleeding occurs in the presence of the proliferative phase of endometrium; serum of pregnant women can be used also for the same purpose. The difficulty with these forms of treatment is that they are merely palliative procedures and must be continued over a more or less prolonged period. And, of course, no hormonal

treatment should be given until the physician is relatively sure that there is no malignant disease present.

Recently considerable attention has been given to the use of the male hormone as a method of treatment of functional bleeding. Huffman[5] found his best results with doses of from 30 to 50 mg. weekly. He assumed that cessation of genital activity is due to inhibition of the pituitary rather than to ovarian suppression. Testosterone propionate can be given subcutaneously or methyl testosterone can be administered by mouth. The disadvantages, according to Huffman, are that the testosterone is likely to cause masculinizing phenomena, especially if the dosage exceeds 200 mg. a month; the treatment is not curative, but merely palliative.

Since the advent of stilbestrol and more potent natural estrogens a new type of bleeding is being seen, namely, that induced by administration and withdrawal of estrogens. For women who are experiencing the vasomotor waves, tension, anxiety, insomnia and so on, that are sometimes concomitant with cessation of menstruation, oral or parenteral administration of an estrogenic substance is the accepted treatment. Use of stilbestrol or other estrogenic hormone in large doses over a short time may cause vaginal bleeding which may not occur until discontinuance of the medication, the "withdrawal bleeding" syndrome. When a woman who has not menstruated for six or more months begins to bleed again, the symptoms must not be disregarded. Occasionally it becomes necessary to do a diagnostic curettage to rule out the possibility of malignancy of the fundus, even though the physician may be relatively certain that the bleeding is the result of administration of the estrogenic hormone.

A review of 200 cases should give a good sampling of the condition under scrutiny. In the series of cases reviewed for this study, relatively atypical proportions were found of the following: (1) minor benign conditions causing abnormal uterine bleeding, (2) more severe benign conditions requiring hysterectomy or irradiation and (3) carcinoma of the uterus. In an average office practice one should encounter a much larger proportion of minor conditions, proportionally fewer cases of fibromyoma, and a still smaller proportion of malignant lesions. This discrepancy probably is an outcome of the tendency of sick people not to undertake a more or less tedious trip for medical care at some expense, unless their symptoms have become aggravated enough to cause them grave concern about their illness.

In this study, we found eighty cases (40 per cent) of uterine fibromyoma and twenty-seven cases (13 per cent) of carcinoma of the uterus, in a total of 200 cases. Results indicated that the more or less prevailing treatment of uterine bleeding in the presence of uterine fibromyoma was usually successful, namely—hysterectomy in most instances if the patient has not reached the age of forty or perhaps forty-two years, to preserve ovarian function, and hysterectomy at any age if the tumor is larger than, perhaps, the size of the uterus when a patient is two and a half to three months pregnant. For patients who are more than forty-two years of age when the uterus is smaller than this and the amount of bleeding demands treatment a dose of radium sufficient to bring on menopause is applied. Aside from exceptional cases, curettage should be performed prior to radium treatment. Radium, when used to control menorrhagia associated with fibromyoma stopped the excessive bleeding in all but two of seventeen cases.

The results of total hysterectomy for carcinoma of the body of the the uterus, with a rate of cure of 63 per cent, appears to justify continuance of this method of treatment. The rate of cure of 37 per cent for carcinoma of the cervix following irradiation with radium and roentgen rays conforms to the usual results. Comparison of the results obtained in early as compared with advanced cases of both carcinoma of the cervix and of the uterus, confirms the opinion that the curability of early carcinomatous lesions is much greater than the curability of those which are more advanced. In a large majority of cases the warning sign of abnormal uterine bleeding was ignored too long.

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MSMS

Congenital Heart Block

Report of a Case

By Leslie T. Colvin, M.D.
and
M. L. Lichter, M.D.
Detroit, Michigan



L. T. Colvin

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We present a case of congenital complete heart block, ventricular rate 46, associated with an interventricular septal defect, in a three-year-old boy. The electrocardiogram showed right axis deviation, complete auriculo-ventricular dissociation and significant T-wave changes. Atropine and ephedrin did not alter the degree of block. Digitalis apparently was of value in relieving the congestive failure occurring with frequent upper respiratory infections. Review of the literature disclosed less then seventy cases of congenital heart block, most of these having associated septal defect.

■ The condition of congenital heart block is described in the literature with sufficient rarity to warrant reporting another case. The first comprehensive compilation of reported cases was made in 1929 by Wallace Yater.[4] He found, to that date, thirty cases of well-established congenital heart block, including one of his own. By well established he meant those cases in which there was a very slow pulse at an early age and in which there was the absence of a history of infection which could have produced an acquired block such as "diphtheria, rheumatic fever, chorea, and congenital syphilis." He further stated that "the occurrence of syncopal attacks at an early age is fairly good evidence of the existence of heart block prior to the attacks. The presence of signs of congenital heart disease, although not essential, adds weight to the congenital origin of the condition; but one must remember that congenital heart lesions, such as a patent interventricular septum, may be the seat of acquired endomyocarditis." Some cases reported he felt lacked proof of the congenital origin of the condition or of the presence of block. Of the thirty proven cases, twenty-two had complete auriculo-ventricular dissociation, six partial, one alternating partial and complete block and in one case the degree of block was undetermined. In fifteen cases there was no cyanosis, in nine slight and in six marked. Nineteen of the cases had an interventricular septal defect diagnosed clinically and in three of these postmortem examination revealed this condition. His own case was diagnosed two weeks before birth from the abnormally slow rate of the fetal heart sounds. There were many other congenital defects in the child. The auricular rate by electrocardiogram was 116, the ventricular 47. His case was one of those in which necropsy was done.

Luvern Hays,[2] in 1934, added nine more well established cases from the literature and three of his own. He pointed out that of the forty-two cases reported up to this time four had come to autopsy and these showed interventricular septal defect and were all without evidence of fetal endocarditis. He pointed out also that where electrocardiograms had been made the initial ventricular complexes were all of the supraventricular type thus placing the interruption of the conducting tissue above the bifurcation of the His Bundle. One of his cases had Adams-Stokes attacks and presumably died in one; while the other two had no symptoms of heart disease. He closed his article by stating that in the absence of Adams-Stokes attacks congenital heart block probably produces no symptoms and does not tend to shorten life.

David B. Witt,[3] in the same year, added two more cases. The first of these was diagnosed two months before birth and the diagnosis was confirmed two days after birth by electrocardiogram. The auricular rate was 130 and the ventricular rate 45. There was cardiac enlargement. The case came to autopsy which showed the interventricular septum to be intact and there was a coarctation of the aorta. The second case had

an auricular rate of 108 and a ventricular rate 52. Adrenalin increased both auricular and ventricular rates while atropine increased the auricular rate, but changed the ventricular rate very little. The first of these cases brought up the question, since many septal defects are not associated with heart block and at least one of the five reported cases autopsied had an intact septum, as to whether there is necessarily a definite anatomical dependence of the two abnormalities.

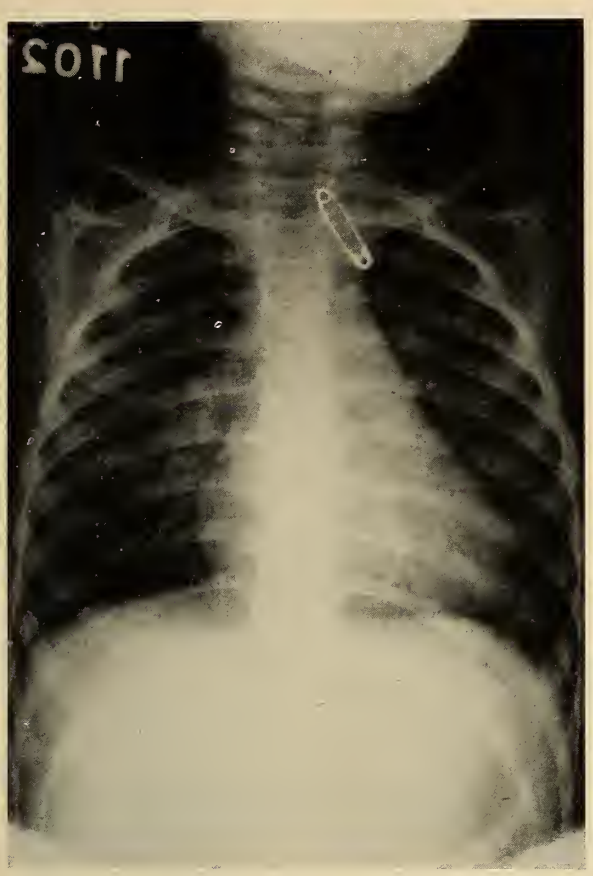


Fig. 1. Chest radiograph taken September 12, 1941, showing cardiac enlargement and increased hilar markings.

Finally, in 1940, C. J. Geiger and L. E. Hines[1] added one case of congenital heart block. This case was, again, diagnosed prenatally, seventeen hours before birth. The fetal heart rate suddenly dropped from 136 to 64. The electrocardiogram showed an auricular rate of 120, ventricular rate 60, and the x-ray showed a heart of normal size and contour. These writers stated that twenty-six or more cases had been reported in addition to the forty-four collected up to 1934. Of these at least three proved, upon investigation by the authors, to be not cases of heart block. Thus the literature contains something less than seventy cases of congenital heart block.

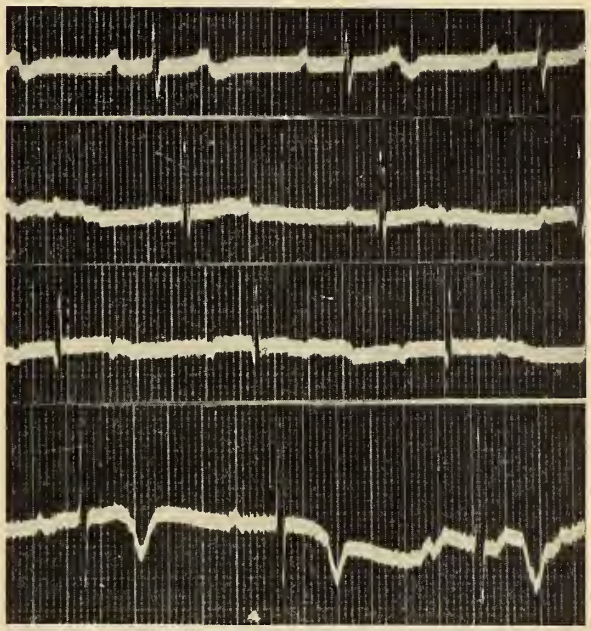


Fig. 2. Electrocardiogram taken September 12, 1941, showing complete auriculo-ventricular dissociation and T waves inverted in leads I and IV.

Case Report

The case we wish to present is that of a three-year-old white boy admitted to Grace Hospital, September 10, 1941. The admission diagnosis was pertussis pneumonia. The most striking observation was the slow pulse rate. Here was a child in obvious respiratory distress with severe paroxysms of cough, and yet at no time was the pulse rate elevated above 58 beats per minute, even after the most violent and prolonged paroxysms. Cardiac examination gave the impression that the heart was enlarged. The rate was 46 at the time of examination. The rhythm was regular, and the sounds of good quality. No thrills were palpated. In the fourth interspace just to the left of the sternum and transmitted toward the apex was heard a harsh systolic murmur. An electrocardiogram was taken and this revealed a complete heart block.

In taking the child's history it was ascertained that he was a full-term baby, delivered normally following an uneventful pregnancy and labor. No information was elicited concerning the condition of the heart immediately following birth. At the age of five months he had measles and bronchopneumonia, and it was at this time the parents were told he had a slow pulse. Subsequently he had frequent attacks of bronchitis, the most severe at the ages of five months, two years, two and a half years, and two and three-quarter years. History was also obtained of episodes during which the

child became pale, lifeless and pulseless to a point where the parents thought he was about to die. He was never markedly cyanosed, but there were occasions when he would have bluishness of the lips and fingernails.

The chest x-rays (Fig. 1) revealed marked hilar

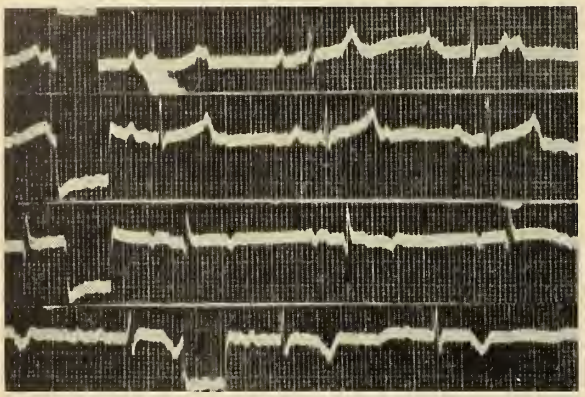


Fig. 3. Electrocardiogram taken January 30, 1942, showing complete auriculo-ventricular dissociation and T waves now upright in lead I but still inverted in lead IV as well as in lead III.

lymphadenopathy, but no pneumonic consolidation. The first electrocardiogram was taken September 12, 1941 (Fig. 2). It shows slight right axis deviation, complete auriculo-ventricular dissociation and T waves inverted in leads I and IV. The laboratory findings were negative except for the white count which was typical of pertussis. A diagnosis was made of congenital malformation of the heart with interventricular septal defect and complete auriculo-ventricular dissociation.

The child responded favorably to symptomatic treatment and x-ray therapy. Following his discharge September 18, 1941, he was given ephedrine sulphate and later atropine sulphate. Neither drug had any appreciable effect on the ventricular rate. February 6, 1942, the patient was readmitted with a temperature of 103 degrees (axillary) and a pulse rate of 64. At this time the diagnosis was bronchitis, and again the striking observation was the hyperpyrexia and the coughing without increase in pulse rate. The electrocardiogram at this time was as previously reported except that the T waves are now positive in lead I (Fig. 3). Again ephedrine sulphate grain one-quarter for six doses a day had no appreciable effect on the ventricular rate. Digitora was then given and the decompensatory features of the picture relieved, and a drop in the pulse rate to a range of forty to forty-two was observed. The chest x-ray, February 6, 1942 (Fig. 4), showed greater cardiac enlargement.

At present the child is leading a normal life. He has had one episode of syncope in the past five months. Occasionally he has mild congestive failure, but digitora has cleared this on every occasion. No change in his pulse rate is ever noted.

Summary

A case of complete congenital heart block associated with interventricular septal defect has been presented. The literature has been reviewed to date and something less than seventy cases of complete congenital heart block have been reported. The lack of effect upon the heart rate of atropine and ephedrine has been noted: digitalization decreased the heart rate but was definitely beneficial in relieving the congestive failure.

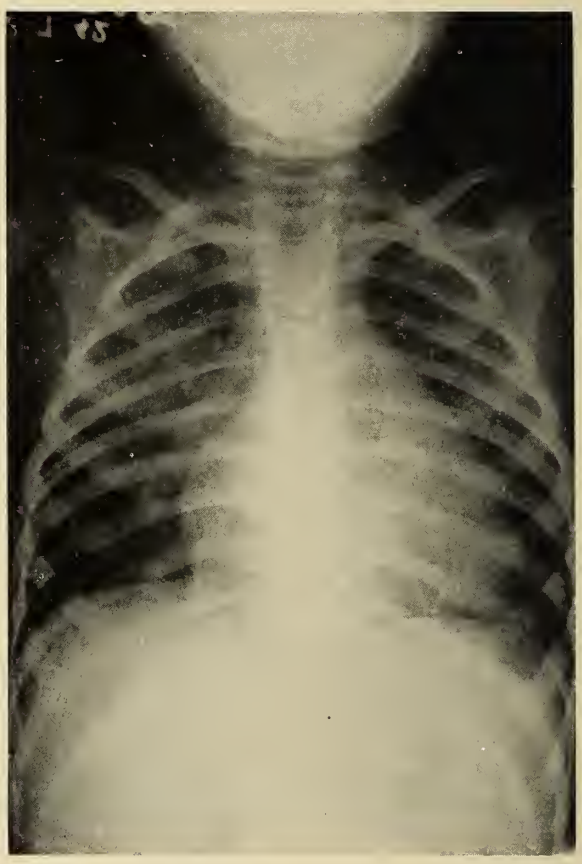


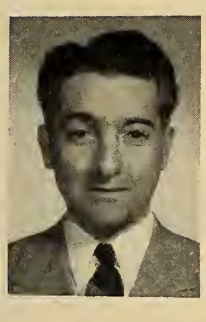
Fig. 4. Chest radiograph taken February 6, 1942, showing more cardiac enlargement than four months earlier.

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An Aid in Abdominal Palpation

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The procedure described below quickly overcomes muscular rigidity in abnormally ticklish and apprehensive patients. It is based on the fact that one is never ticklish to the touch of his own hand.

■ The procedure described below has been found very successful in quickly overcoming muscular rigidity due to apprehension and ticklishness. Although the method may be in frequent use the writer has found no reference to it in the literature.

To try to make the patient relax, several preliminary steps are taken. His back must not be arched as he lies comfortably on the examining table. He places his hands loosely by his sides, flexes his knees and breathes quietly through his mouth. He is assured he will not be hurt. The examiner's hands must be warm. If the abdominal wall continues to remain rigid the following procedure is carried out.

Procedure

The patient's hand is placed upon his own abdomen and the examiner's hand is placed directly over his (Fig. 1). Invariably the abdominal muscles relax immediately and confidence is quickly won. The entire abdomen is thus palpated, his hand being guided by the examiner's left. Real tenderness and rigidity can be determined in this manner.

The examiner then slides his right hand forward a little, so that the tips of his fingers overlap those of the patient and touch the abdomen (Fig. 2). In this way the lower border of the liver and any possible mass can be outlined. Bimanual palpation can also be carried out to determine a palpable spleen, kidney or ballottable mass (Fig. 3).



Fig. 1. Patient's hand placed on his own abdomen. Palpation carried out by pressure on his hand with examiner's right hand. His hand is directed with the examiner's left.

Fig. 2. Examiner slides his hand forward so that his fingers overlap those of the patient and touch the abdomen.

Fig. 3. Bimanual palpation with the patient's hand on his abdomen and examiner's left fingers overlapping those of the patient.

The patient's hand is now slowly slipped out from under the examiner's. In many instances abdominal palpation can then be continued in the usual manner.

What Price General Paresis?

By William Scholten, M.D.
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M.D., University of Nebraska, 1914; A.B., 1916; Assistant Physician Kalamazoo State Hospital; Member of American Medical Association; Diplomate American Board of Psychiatry.

A study of the course of 356 cases of general paresis whose disease had advanced to such a degree that hospitalization became necessary is presented. The methods of treatment in state hospitals are rather indiscriminate. The cases who survived the malaria therapy were usually subjected to chemotherapy. No controls were ever used to determine the value of the added therapy. The results of all therapy were generally discouraging. Patients too weak for malaria therapy do not respond well to chemotherapy. A few who escaped all forms of treatment survived along with those treated.

Histological studies reported on twenty-three brains postmortem are of particular interest. In advanced cases of paresis the disease advanced despite any treatment given. Less advanced appear to have been arrested by malaria therapy. One fairly early case who was practically immune to malaria did not have the disease arrested by extensive chemotherapy. Early treatment by fever therapy appears to be the means of stopping the ravages of this disease.

■ The purpose of this article is to reveal what the prognosis is for a patient after the disease has advanced to such a degree that it is necessary for him to enter a hospital for mental disorders. Some suggestions will also be made in regard to what may be done to lessen the ravages of this disease.

As a basis for this study a review was made of the cases falling within this classification who entered the hospital in the period between 1927 and 1933 inclusive and over a period of seven years after each admission. A résumé of the postmortem finding on the few brains that came to autopsy is also presented.

Every case history in which a form of neural syphilis was the clinical diagnosis was reviewed. Only those which met the following criterion as a basis for the clinical diagnosis of general paresis were accepted. This consisted of: (1) a positive Kahn or Wassermann report on both blood and cerebrospinal fluid; (2) a positive report on the cerebrospinal fluid with positive findings in the colloidal gold and mastic curves; (3) a positive report on cerebrospinal fluid with neurological findings indicating a diffuse central nervous system disorder; (4) neurological findings indicative of a diffuse central nervous system disorder plus a history of former positive serology. Most of the cases meeting this criterion had the diagnosis of general paresis but a number were also diagnosed psychosis with cerebral syphilis. The medical staff at this period used no definite criterion for a differential diagnosis between the two forms of mental disorder. The type of the colloidal gold curve as described in textbooks was often the deciding factor.

The basis for treatment of general paresis in state hospitals appears to be traditional rather than empirical or scientific. Before the advent of the malaria treatment the prevailing methods for treatment of syphilis in general were applied. There appeared to be but little regard as to the efficiency of the treatment applied. After the results of Wagner von Jauregg's experiments in treating general paresis with malaria fever therapy was published, this form of treatment was added. It was introduced in the Kalamazoo State Hospital in the first year of the period selected for this study.

The chemicals administered consisted of about an equal number of arsenical preparations intravenously and a heavy metal intramuscularly. The arsenical used consisted largely of neoarsphenamine, some sulpharsphenamine and a lesser amount of tryparsphenamid. The heavy metal used consisted largely of mercury succinamide and bismuth salicylate.

The classification card index showed that some form of neural syphilis was the clinical diagnosis in 403 cases during the seven-year period. Of these forty-seven cases were rejected as not meeting the above-mentioned criterion. In a few of these syphilis probably was the etiological factor in producing the psychosis but could not be included because no cerebrospinal fluid examination had been made.

The remaining cases, 356 in number, are divided into five groups for the purpose of this study. These are: (1) those who died within the first year following admission; (2) those leaving the hospital within the first year following admission; (3) those who died within the second to seventh year following admission; (4) those leaving the hospital within this first to seventh inclusive following admission; (5) those remaining in the hospital at the close of the seven-year period.

TABLE I

Group	None	Malaria Only	Chemo-therapy Only	M. & C.	Total
I	18	13	46	17	94
II	2	9	14	55	80
III	8	2	33	23	66
IV	0	4	12	39	55
V	4	2	15	40	61

TABLE II

	Chemotherapy Only			Malaria and Chemotherapy		
Group	No. Pts.	Range	Average	No. Pts.	Range	Average
I	46	1–34	14	17	6–27	15
II	14	2–34	17	55	2–41	17
III	33	2–60	34	23	4–80	41
IV	12	7–44	35	39	3–116	39
V	15	1–120	48	40	2–120	55

Table I shows the type of treatment each group received.

Table II shows the amount of chemotherapy received by each group.

On analyzing the above data it is of interest to note that the small number (thirty-two) receiving no treatment fall in all but one of the five groups into which the cases were divided and that only eighteen belonged to group I. Several of these died before a reasonable time had elapsed for the institution of treatment.

Of the number (thirty) having malaria only, it will be noted that the number dead, fifteen, equals the number in the other three groups. The former number is seemingly high but death prevented them from being subjected to chemotherapy.

Of the number (120) having chemotherapy only seventy-six or four less than two-thirds are dead. This number, too, is seemingly high but it included a number who were considered poor subjects for malaria therapy.

The group receiving malaria plus chemotherapy is large (174) because it contains the less advanced cases who were able to endure the malaria treatment, thus making them available later for chemotherapy. Death, however, claimed fourteen, less than one-fourth of that number.

The above data then reveals that there was no uniform plan of treatment. No controls were ever used to test the efficiency of any plan of treatment. There is nothing to indicate that a more extensive treatment prolonged the life of a patient rather than that the prolonged life of a patient permitted a more extensive treatment.

The postmortem studies are more revealing. From the 160 dead only six brains were removed for a histological study. General paresis was the finding in five of these. These five were subjected to chemotherapy only receiving from four to sixty treatments, an average of twenty-six.

The sixth case, E.H., showed some non-specific cortical changes. He entered the hospital in a state of acute maniacal excitement. He was given the malaria treatment soon after his admission. He then received forty-two intravenous treatments of arsenical preparations and twenty-seven intramuscular treatments of bismuth preparations over a period of three years. He became jaundiced during his last illness. Gross changes were noted postmortem in the spleen and liver. Histological studies were made of these organs and a diagnosis of malarial spleen and subacute necrotising hepatitis was reported. Arsenic probably was the etiology of the latter.

A histological diagnosis of general paresis was reported on thirteen brains obtained from cases not belonging to the above group. Of these eleven were of comparatively recent admission. The disease was in an advance stage in ten cases. Of these three received no treatment, three received chemotherapy only and four malaria plus chemotherapy. Those having chemotherapy only received from fourteen to thirty-nine treatments, an average of twenty-nine. Those having malaria plus chemotherapy received from seven to 126 treatments, an average of forty-six.

The other case, R.R., entered the hospital in a state of acute maniacal excitement. He made a good adjustment and was out on parole for a period of three years. He was inoculated with malaria after each admission. The first resulted in two major elevations of temperature and the second in three. His chemotherapy consisted of forty-five treatments during his first stay and twenty-five during his second.

The other two cases of this group, I.B.E. and J.A., were long hospital residents, twenty and twenty-four years respectively. The former earlier had a few sporadic treatments of a mercury preparation and eight intravenous treatments of neoarsphenamin seven years

after her syphilis was discovered. On a previous admission she had a negative blood report and was classified epileptic psychosis. She was clinically such throughout her hospitalization. Her blood and cerebrospinal fluid reports were negative for a number of years prior to her death. J.A. received forty-seven treatments of chemotherapy six years after his admission. This produced no change in his bedridden condition.

Three other cases of interest are presented.

The histological report on the brain of P.M., serologically positive, was glioblastoma multiformi. Studies of areas not involved by the tumor reveal non-specific atrophy and deterioration. Besides malaria he received forty-five treatments of chemotherapy. He also received some chemotherapy before admission.

The brain of D.C. was reported as having cerebral and cerebellar changes associated with alcoholism and convulsive phenomena. A plus 1 Kahn was reported on the first specimen of blood, but a subsequent blood and cerebrospinal fluid Kahn was reported as being negative. Patient's ironed-out facial expression, slurring speech, slow movements, unequal pupils and hyperkinetic patellar responses made a rather typical picture of general paresis.

A report of non-specific pathology was received on the brain of M.D. Her clinical diagnosis of general paresis was based on positive blood and cerebrospinal fluid findings and typical paretic colloidal gold and mastic curves. Clinically she presented a rather typical picture of schizophrenia. She was treated with malaria and twenty injections of neoarsphenamin. Her serological findings were never checked. She died of carcinoma of the uterus.

Of those leaving the hospital not too much is known. Some are known to have made a good adjustment and even an apparent recovery. A number lived comfortably outside of the hospital but not self-supporting. Some were a trial to their family who put up with them rather than return them to the hospital. Several are known to have died.

Comments

From the above study it is noticed that the result of the treatment of a case of general paresis after entering the state hospital is not so very encouraging. There is nothing to show that advanced cases yield to any form of treatment.

No conclusions can be drawn that malaria plus chemotherapy has any advantage over malaria alone as no controls were used. The postmortem finding in the case of E.H. shows that arsenicals cannot be pushed with impunity. The findings here suggest that an apparently early case of general paresis was arrested by malaria therapy and then died from the effects of arsenical therapy.

Due to his immunity to malaria, R. R., although an apparently early case of general paresis, could not benefit by fever therapy. The disease progressed in spite of the chemotherapy. The case of D. C. suggests that general paresis may terminate spontaneously. The case of M. D. suggests that her mental symptoms were due to schizophrenia. Her paresis being in an early stage yielded to the malaria treatment. The case of P. M. suggests that paresis and brain tumor were concurrent disorders, the former yielding to malaria therapy.

It appears then from the above postmortem findings that early cases of general paresis yield to malaria therapy but the later cases yield to no form of treatment.

The early detection of this disorder then is important. It is urged that every physician be on the alert to detect latent syphilis in his patients. If the blood test is positive, a cerebrospinal fluid examination should be made. If the latter is positive no time should be wasted on chemotherapy but malaria or some other form of fever therapy instituted at once.

Every hospital should insist that a routine blood test be done on each patient admitted.

If the above procedures were followed the ravages of syphilis would be greatly reduced.

MSMS

"ON THE RUN"

Poison ivy plants may be easily killed with a spray solution of ammonium sulfamate.

* * *

Inositol, a member of the B complex group, has been found to check tumor growth in mice when given intravenously.

* * *

Lying on the back and elevating the legs to nearly a right angle with the body, while resting the heels against any object, will overcome leg weariness. The procedure should take exactly four minutes.

* * *

Hexenolactone, occurring in the red berry of the mountain ash, has been found to stop growth of scar tissue and to stimulate growth of normal tissue.

* * *

The more acute the tuberculous process the more frequently does effusion occur as a complication.

* * *

The Kahn verification test is useful in differentiating between the positive Kahn tests in malaria and syphilis.

—W. S. R. in *Detroit Medical News.*

Osteogenic Sarcoma of Upper Third of Femur

Well Ten Years after Disarticulation at the Hip Joint

By Harry C. Saltzstein, M.D.
Detroit, Michigan



Yale University, Ph.B., 1910; Johns Hopkins, 1914; Mt. Sinai Hospital, New York, New York, 1914-17; Captain World War I, Base Hospital No. 3, AEF, 1917-19; Assistant Dr. Max Ballin, Detroit, 1920-23; Active Practice General Surgery, Detroit, since 1923; Assistant Surgeon Harper Hospital; Surgeon North End Clinic; Surgeon Mercy Hall Tumor Clinic and Hospital.

An osteogenic sarcoma arising in the upper third of the femur in a boy aged eighteen was removed by disarticulation at the hip. Patient is well ten years later and well rehabilitated both as to his economic and social status.

■ The general medical opinion about certain types of malignant tumors is still so pessimistic, and treatment is often undertaken with such an atmosphere of pessimism and hopelessness that it was felt worthwhile to place this case on record.

Case Report

D.Y., age eighteen, was first seen May 2, 1932, referred by Dr. S. Rosenzweig. While playing basketball four months before, another player came down hard upon the patient's right thigh with his knee or heel during a scrimmage. The boy's thigh felt sore for two or three weeks. Swelling started two days after the injury. Ever since, his muscles ached after exercise. There has been a slow growth of a tumefaction at the site of injury (outer surface of right thigh). Now there has been some discomfort in walking. He states that for the past three weeks he has limped slightly. There is no pain at night.

Examination showed a young boy, rather small frame but wiry build and very markedly hirsute over his entire body. Complexion was dark. General examination was negative except for the lesion in the right thigh. At about the middle third there was a visible tumefaction on the outer surface which felt like solid bone. It measured about thirteen centimeters longitudinally and 5.5 cm. transversely. The upper border and the lower border seemed well demarkated but the lateral border seemed diffusely blended with the femur. There was slight tenderness over the tumor, but there was no fluctuation.

X-ray examination, May 3, 1932, by Dr. William Evans, showed an "irregularity in the cortex of the bone at the junction of the middle and upper thirds, the pathological process extending along the shaft for a distance of twelve centimeters. There is new bone formation of periosteal origin, extending into the soft tissues in the so-called ray formation. Diagnosis: Osteogenic sarcoma." (Fig. 1)

Biopsy of the mass was performed May 7, 1932: A three-inch longitudinal incision on the lateral anterior surface of the thigh, along the outer upper margin of the tumor, was made. The tumor lay underneath the fascia and muscle. It was a soft, grayish, apparently cellular mass, and cut into very easily.

Diagnosis: (Dr. P. F. Morse, Harper Hospital) "Fibro-chondro-sarcoma. Very low grade of malignancy. Very few localized areas of cellular activity. The fibrous and cartilaginous structures are developing quite typically. The mass will recur locally if not all removed. Will be more malignant at successive recurrences but will not metastasize at this time." (Fig. 2)

The family were unwilling to consent to high amputation, and sought several opinions from well-known individuals and institutions. In view of the subsequent history of the patient, these various pathological and clinical diagnoses and opinions are worth noting. Dr. Ballin suggested resection of the tumor, and a long inlay bone graft. He gave it as his opinion that "there was a 10 per cent cure with amputation, and if resection were attempted the prognosis was somewhat less favorable."

Dr. Weller of Ann Arbor diagnosed it as spindle-celled osteo-chondrogenic sarcoma, and advised high amputation. Dr. Meyerding of the Mayo Clinic diagnosed it as grade 2 osteogenic sarcoma, and advised high amputation, followed by x-ray therapy to the groin.

The slides and radiographs were sent to Dr. Bloodgood and Dr. Geschickter in Baltimore. Dr. Geschickter of Baltimore diagnosed malignant osteogenic tumor, largely composed of cartilage cells and therefore not favorable for resection. The tumor does not respond well to radiation. "The only possible cure is high amputation and this offers not more than 10 per cent because of the high location, extending well up into the junction of the upper and middle third. The size of the tumor suggests a cartilaginous growth."

He visited the Cleveland Clinic May 24, 1932. Dr. Dickson of the orthopedic department noted "hard non-fluctuant swelling; x-ray shows spicules of a periosteal sarcoma. Do not feel that any treatment is indicated. ? amputation." "Graham Dickson and I (Dr. George Crile) agree on amputation with meager prognosis as to life."

After this weight of authorative opinion, the family finally consented to disarticulation at the hip. This was done May 26, 1932. The operative notes are as follows: "Racquet incision starting at Poupart's ligament curving around outer side of the thigh at the level of trochanter and on the inner side about three inches below the groin, making a large external muscle flap and shorter internal flap. Femoral vessels were first ligated doubly just below Poupart's. Skin flaps were outlined, fascia incised and the gluteus medius divided above the trochanter. Pectineus and ileo psoas



Fig. 1.

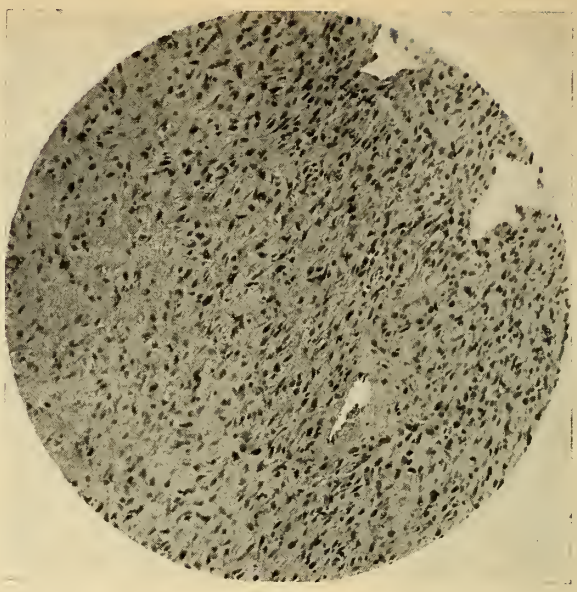


Fig. 2.

Fig. 1. Radiograph taken May 3, 1932. "Irregularity in cortex over a distance of 12 cm. Some new bone formation of periosteal origin, extending into the soft tissues into the so-called ray formation."

Fig. 2. Microscopic appearance of tumor.



Figs. 3 and 4. Appearance April 18, 1942, ten years after disarticulation at hip.

divided on anterior thigh, dissecting out branches of profunda femoral arteries. The posterior hip joint muscles were then divided and the capsule completely divided, severing the femoral head from the socket. The round ligament was then divided and the small rotating posterior muscles all divided. The gluteus maximus next cut leaving the leg attached only by means of middle adductor group. These were divided in form of a flap and the leg was taken away. Closure: the flap was slightly short, muscles covering the bone socket not entirely complete and the skin was approximated under slight tension. Otherwise his condition was satisfactory. There was only moderate hemorrhage. There was some slight shock after the operation which responded immediately to indirect blood transfusion." Convalescence was slightly prolonged because of some necrosis of the skin flap. An open granulating area was covered with a heavy Thiersch graft on July 9, 1932.*

He was considerably depressed for a time and found some difficulty in wearing his prosthesis. This had to be worn with a bucket going around his pelvis. However, one day in April, 1933, he appeared in the office smiling and said he had just finished nine holes of golf. Asked how he got out of the bunker with his artificial pelvis and wooden leg, he replied simply that he had the caddie hold his wooden leg while he swung and pitched the ball directly onto the green.

In August, 1934, he finished high school. Two years later he moved to San Francisco, where I learned subsequently that he had rehabilitated himself completely, was managing a gas station and had married. He appeared in my office April 18, 1942, bright as life, saying that he had had no discomfort since the operation. He can walk three miles with his artificial leg and is in an active tire repair business. He has a daughter four years old. Stump is well healed and locally negative (Figs. 3 and 4).

*Pre-operative x-ray therapy was given by Dr. T. Leucutia. Details of the therapy:

5-7-32: 100 mgs. colloidal lead phosphate injected intravenously.

5-8-9-32: deep x-ray therapy was given over the site of the tumor of the right thigh with 200 kv., 15 mm. cu., 1 mm. al., 50 cm. std., 20 ma., 20 r/min., 2 portals for cross-firing, total dose 130 per cent SUD.

5-10-11-32: Deep x-ray therapy was given over the lungs, with 200 kv., 1.5 mm. cu., 1 min. al., 50 cm. std., 20 ma., 20 r/min., 4 portals for cross-firing, total dose 130 per cent SUD.

MSMS

Bureaucracy will try to keep its hand on the helm and increase its powers, as it has always done, and, since bureaucracy is essentially sadistic, it will constitute an ever-present threat to democracy and those freedoms that are still left after the fight for freedom is finished. Here, too, lies our own greatest danger, in the federalization of medical practice. If this comes in, individual enterprise goes out, and another freedom with it. —*New England J. Med.*, December 23, 1943.

Primary Atypical Pneumonias of Unknown Cause: "Virus" or "Viral" Pneumonias

Case Report of a Similar Disease Without Pneumonia

By Hobart A. Reimann, M.D.
Philadelphia, Pennsylvania



Professor of Medicine Jefferson Medical College.

During the past five years a form of pneumonia previously unrecognized has been found to be widespread. Because of certain peculiar characteristics of the disease, a filterable virus is supposedly the cause and a number of "new" viruses associated with pneumonias have been isolated. In the majority of cases, however, the cause is still unknown.

The clinical characteristics of the disease as contrasted with the better known forms of pneumonia, its epidemiology and its treatment will be discussed. Diagnosis is of especial importance since the sulfonamide compounds are useless in therapy and mortality rate is nil.

▪ Because of the numerous reviews[2,3,5,9,10] during the past year or two of the pneumonias associated with filtrable viruses, there is no need for another on this occasion. In most of the published papers comment is made on the great number of cases which occurred during the past season, especially in military organizations here and abroad, and detailed descriptions of the etiologic, clinical, roentgenographic, diagnostic and therapeutic aspects of the syndrome are given. Actually very little new has been added except for the isolation of a few more ill-defined viruses from a small proportion of patients, the use of the complement-fixation test in diagnosis, the occurrence of hemolytic crisis and encephalitis as complications in a few cases and the discovery that a cold agglutinin develops in a high percentage of cases. The purpose of this paper is a discussion of some of the newer contributions.

Authors are still puzzled as to whether or not

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the disease "virus pneumonia" is a new one, having just appeared within the last decade. There are many reasons to believe that it is not new but has always been with us, unrecognized or undelineated among the large group of grip-like or influenza-like infections with symptoms referable to the respiratory tract. Its apparent diversity of cause together with published reports of clinically similar disease during the past seventy years favor this view. Probably the chief reasons for its apparent or actual increase and widespread distribution at present are the recent knowledge of its existence as a syndrome, the more frequent use of roentgenography as an aid in diagnosis, the recognition of true influenza as a separate disease, and the high incidence of the disease in the military services and in the civilian population.

Terminology.—In addition to the array of descriptive names already applied to the disease, including those in the title of this paper, which need not be repeated here, new ones equally unsatisfactory have been proposed. They are: "sulfonamide-resistant pneumonia" which is self-explanatory but includes any pneumonia resistant to these drugs; "silent bronchopneumonia," because of the delayed or absent physical signs of pneumonia; and "acute bronchiolitis with atelectasis." The words "typical atypical" and "atypical atypical" pneumonia have actually appeared in print. It is questionable whether the word pneumonia should be used at all in naming the disease since in the majority of cases of apparently the same infection, pneumonia is not present. Terminology will continue to be confused until the causative agents are eventually discovered. One example may be cited to illustrate an orderly approach to the problem: The discovery of the virus of "ornithosis" has permitted the disease it causes to be removed from the heterogeneous viral pneumonias and called ornithosis as a specific entity in which pneumonia usually occurs.

Etiology.—The following viruses are known to cause viral pneumonias in man or in experimental animals: influenza, measles, vaccinia, variola, varicella, lymphocytic choriomeningitis, psittacosis and its relative ornithosis, and lymphogranuloma venereum. These viruses apparently cause a minority of cases. Complement-fixation tests for the composite psittacosis-ornithosis-lymphogranuloma venereum-mouse meningopneumonitis group of viruses give positive results in a small proportion of tested cases and suggest that one of these viruses may have been the cause. The following elusive viruses have been discovered, but are not conclusively related to disease in humans: the first virus isolated during etiologic studies of the diease as such from the patients whose cases I reported in 1938, the mongoose infectious virus of Horsfall, the cotton rat infectious viruses of Eaton and of Dingle, the viruses isolated from cats by Blake and by Baker, and the guinea pig infectious virus of Rose and Molloy. A review of these contributions is published elsewhere.[9,10]

There remains the great majority of cases comprising a syndrome tentatively called "viral pneumonia" for which no infectious agents have been discovered. They are similar to each other and to the pneumonias of known viral origin just mentioned, and there is reason to believe that a number of viruses may be implicated. The question arises as to whether several different viruses are operative or if there is only one virus which continually changes its characteristics and defies identification. The problem may be analogous with that of influenza.[6]

The frequent presence of the Streptococcus viridans in the sputum during the disease has led several investigators to suspect its causal relationship, but until its pathogenicity or participation can be proved it must be regarded as a commensal.[9]

Special Diagnostic Tests.—Attempts to isolate a virus need complicated procedures and equipment. The complement-fixation tests, just mentioned, aid in identifying influenza and the psittacosis group of virus diseases, but doubt has recently been cast on their specificity. Influenza may also be identified by Hirst's newly devised test.

According to recent observations,[4,8] erythrocytes agglutinate when suspended in the refrigerated serum from the majority of patients with "viral pneumonia." The "cold agglutinin" responsible for the reaction develops during the second week of the disease, reaches its highest titer between the tenth and twentieth days, slowly diminishes, and disappears after several weeks or months. The reaction may prove to be a valuable diagnostic aid if further studies confirm

its reliability and specificity. But the problem is complicated by the recent observations of Damashek[1] who reported an acute hemolytic crisis and a cold agglutinin in two cases of "viral" pneumonia in which sulfonamide chemotherapy was used. He suggests that a combination of a high titer of abnormal agglutinin *and* the effect of a sulfonamide compound may be the cause of this serious condition. Similar episodes were noted by others.[8] On the other hand, a cold agglutinin was not found in other infectious diseases treated with sulfonamides, and it was present in patients with viral pneumonia who had not received sulfonamides.

Clinical.—The clinical signs, symptoms, and routine laboratory studies have been described in more than a dozen papers during the past year and need no repetition. A few unusual circumstances merit discussion.

According to my own observations, the syndrome in general may be separated into two large groups: (a) the *sporadic form* represented by most of the known viral diseases already listed under "Etiology" and of others of unknown origin. The diseases in this group are usually nonseasonal and occur usually in severe form in isolated cases, or in small groups of cases of similar severity about a single focus, resembling psittacosis in clinical and epidemiologic behavior. In many cases it seems to be an infectious systemic disease, occasionally with splenomegaly, in which the lungs and respiratory tract are incidentally involved; (b) the *epidemic form,* in which large numbers of persons are affected, most of them with mild naso-pharyngo-laryngo-tracheobronchitis and a small proportion with actual pneumonia, which in many cases is discovered by roentgenography alone. Most of the cases reported during the cold months from military camps and among civilians have apparently been of this contagious form, and it is in this form that the least progress has been made etiologically.

Evidence that the sporadic form is a systemic disease is supported by the frequency of severe, typhoid-like sickness with evidence of minimal pneumonia or occasionally with no demonstrable pulmonary involvement at all, which calls into question the use of the term "atypical pneumonia" or especially of "primary atypical pneumonia" in naming the disease. The problem is illustrated in the following case report:

A boy, aged seventeen, noted dryness and "tickling" of his throat on June 22, 1943. He felt tired all day and had a slight but persistent unproductive hacking cough. Toward noon he noted substernal discomfort. His temperature rose to 38.9 C (102 F) and severe headache obliged him to go to bed. On the second day cutis anserina occurred several times, but without chilly sensations. Sulfadiazine was given by his physician without beneficial effect. That night he was nauseated and perspired profusely. Diarrhea occurred for two days and the dry cough persisted. On the third day his temperature varied from normal to 39.5 C (103 F). Because no improvement accompanied chemotherapy he was sent to the hospital on the fourth day.

On examination there was no conjunctival injection, but the oropharyngeal mucous membrane was abnormally red and dry. There were no abnormal physical signs in the chest at any time during the period of observation. The abdomen was slightly distended and the spleen was not palpable. From the fourth to the ninth day of disease the slight cough persisted which later produced a small amount of uncharacteristic sputum. Headache was at times intense, and sweating occurred especially at night. There was drowsiness and somnolence. The temperature remained rather constantly between 39.5 C (103 F) and 40.6 C (105 F) until the seventh day, then gradually diminished until it became normal on the twelfth day. There was relative bradycardia, the pulse rate averaging 90 per minute, and the respiration rate was generally normal. The patient was severely sick.

The leukocyte count varied from 6,000 to 9,000 and the sedimentation rate of erythrocytes was slightly increased to 20 mm. in forty minutes and to 23 mm. at sixty minutes. Roentgenograms made on the fourth, seventh and twelfth days showed no abnormalities other than a slightly increased prominence of the hilar and trunk shadows consistent with acute trachobronchitis.

The gradual onset of the disease with slight cough, intense headache, diarrhea, and later the somnolence, high continued fever, profound sickness, bradycardia and the normal leukocyte count so strongly suggested typhoid fever that appropriate measures for isolation were used, but all cultures of the blood were sterile, and those of the stool and urine revealed only the usual flora. The Widal test on the eighth and eighteenth days gave negative results. Because the patient apparently had intensive treatment with sulfadiazine, and 6.3 mgs. were still present in 100 c.c. of blood when he was admitted to the hospital, drug fever was also suspected. During convalescence, however, 3 grams of sulfadiazine given on two occasions did not cause fever or other symptoms.

This patient's sickness was an isolated instance and occurred in hot weather in June. There was no similar disease in the patient's family or immediate contacts as far as could be determined, and respiratory tract infections were minimal

elsewhere in the community. There was no contact with psittacine birls, poultry, pigeons or small animals.

Because the clinical picture resembled that of the sporadic form of "viral pneumonia" except for the absence of pneumonia, this disease was considered in diagnosis, and resort was made to the newly discovered cold agglutinin test. Tests made on the fifteenth and sixteenth days of disease gave positive results respectively in titers of 1:1,000 and 1:8,000, the highest dilutions tested. The titer on the twenty-third day was 1:250,000 (microscopically, using the patient's own serum and erythrocytes) and a month later 1:4. Complement-fixation tests made by Dr. Thomas Francis on the serum taken on the fifteenth, thirty-second and seventieth days for the psittacosis-ornithosis group of viruses gave negative results; the titer for influenza A, using the chicken red blood cell inhibition test, was 64, 64 and 64; but the titer for influenza B was 256, 512 and 128, respectively. The rise and fall of the titer during convalescence suggests the possibility that the virus of influenza B may have been implicated except for the high titer of 256 during the acute phase.

If the cold agglutinin test is reliable and specific, it confirms the diagnosis of "primary atypical pneumonia of unknown cause," or "viral pneumonia," *without* pneumonia, illustrating the appellative dilemma already mentioned. A cold agglutinin did not appear in other respiratory tract diseases nor during influenza A in Meiklejohn's cases.[7]

Another peculiar and unexpected circumstance has been noted in my own experience and in that of others: fairly extensive pneumonia, detected only by roentgenography, occasionally occurs in patients who have no fever and who are not sick enough to remain in bed.

Treatment.—Almost every author who has studied the disease agrees that symptomatic treatment alone suffices. The infection in the vast majority of cases is self-limiting, it is often mild and the few deaths which have been reported from it have occurred mostly in patients who had had other chronic disease as well. All authors agree that the sulfonamide compounds have no effect on the disease, often add to the patient's discomfort and should not be used unless the diagnosis is doubtful. If Damashek's[1] suggestion is correct, and a combination of sulfonamide effect together with an abnormal agglutinin results in a serious complication, sulfonamide therapy is actually contraindicated. Should pneumococcal or hemolytic streptococcal pneumonia be suspected, a sulfonamide may be tried but discontinued if the disease is later diagnosed otherwise or if no improvement occurs within forty-eight to seventy-two hours. Reasonably accurate diagnosis of the pneumonias requiring chemotherapy can usually be made clinically and bacteriologically during this period.

Favorable results from the use of convalescent serum have been reported but the specificity of its effect is doubtful. There is no need for transfusions of blood unless severe anemia is present. Several physicians, usually roentgenologists, have applied roentgen ray therapy to the involved lungs and believe to have hastened recovery. There is no proof that roentgen rays accomplish this purpose. Penicillin has been tried without success in one reported case.

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MSMS

Stiff elbows, fingers, hips and knees are suitable joints for arthroplasty.

* * *

Part of the deformity associated with Erbs paralysis may at times be relieved by division of the subscapularis tendon.

* * *

The treatment of congenital wry neck should be instituted as soon as it is diagnosed.

—Eugene W. Secord, M.D., Detroit.

Free Enterprise in Medicine

Permit me to quote a few statements made in the House of Representatives, December 7, 1943, by The Honorable A. L. Miller of Nebraska:

"The practice of medicine under the free institutions of this country of ours has advanced the healing art until it is the envy of the whole world. In the short space of 150 years it has so improved the health of this Nation that the life expectancy has been nearly doubled. Where it was 35 years, it is now 63 years. New techniques for treating disease have been developed and new drugs have been discovered. The sulfa drugs and penicillin are just the latest examples. Free men with great minds have founded medical schools and colleges and established laboratories for research. There has been a ceaseless probing and searching of the unknown for the purpose of curing disease. Many of the terrible diseases of the past have been rendered almost harmless. Today, twice as many of our wounded now recover than in the last World War.

"Under the Wagner-Murray-Dingell Bills the Federal Government would set up a political control of the practice of medicine. It would be a step in which not only the physician but the individual would be regimented, pigeonholed, blueprinted and made to do a physical, mental and ritualistic goose step. The first move in a socialistic government has always been to deal with the health and the welfare of the Nation."

During the past year, we have seen how one Bureau (U. S. Children's Bureau) through its bureaucratic thinking and its directives has whipped into line the medical profession in every state with but one or two exceptions. This is just a small entering wedge. Are you doing your part to prevent a repetition of this on a larger scale? Are you fighting to keep free enterprise in Medicine—and to KEEP OUT a complete medical bureaucracy?

C. R. Keyport

President, Michigan State Medical Society.

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President's



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EDITORIAL

EVOLUTION AND BUREAUCRACY

■ THE problem of Socialized Medicine seems to have struck a new gait in Michigan.

Until now it has been the headache of the medical profession, with many only meagerly informed as to the problem involved, the condition for which we are heading, and the means to be used in combating the revolution through which we are passing.

That it is a revolution cannot be gainsaid. The extent to which it will go can only be told by study and direction of the forces at work. The practice of medicine has been passing through a series of such changes almost constantly since the founding fathers came to these shores. The books, journals and formulary in use, the means of transportation, education and practices are all so changed that there is no resemblance of early medicine to our present-day medical life. The medical changes in practice, education and surgery are so different now from what they were during the youth of our present leaders that it is scarcely the same profession.

This has been revolution, but we call it evolution. These changes are still going on, and at an even greater rate. Medicine can take that sort of change and be improved by it. One has only to look at the record. The most healthful nation in the world, the lowest death rate, the smallest maternal mortality, the lowest infant mortality, the least morbidity. These are revolutionary accomplishments and should still the misdirected zeal of the disciples of change who wish to regiment medicine.

Such a change is healthy, is that embodied in natural growth, and would lead to great things in the future. But change brought on by compulsion, change intended to make for regimentation and for control by dictatorial authority is unhealthy and is a menace to proper development.

Change of some sort is imperative. Not to change is to retrogress. The great problem of medicine today is to control that change ourselves, to direct our own destiny as we have in the past. Change in medicine that comes from within can be, and will be beneficial, if WE look after the direction, and if we sidetrack the long-haired social dreamers and self-seeking would-be administrators who aspire to leadership without the ability to originate, or to know the PROBLEMS of medicine, much less their solution.

But bureaucracy sees a chance to increase its own stature by finding another great movement that it may step in and TRY to direct. Bureaucracy thrives by directing movements or programs that it has never initiated. These proponents of regimentation have done nothing to place the field of medicine and health where it is today, and that profession would never have accomplished half what it has with the curbs and the hindrance that now threaten. We do not want a host of nonmedically trained men to tell us what medicine we may practice, where, or when; nor to tell us what drugs or surgical procedures we may use. Far more important: *Our patients do not want to be told what doctor they may employ, or what hospital they may use.*

DEVELOPING A PROGRAM?

■ THE Michigan State Medical Society has just held a meeting of the secretaries of the County Medical Societies of this state that was a historic event in Michigan medicine. This group has been meeting for many years, discussing the problems of organization, and the work of the executive officers of the medical societies. In the past this has also included the presidents of the county societies, and the officers and Councilors of the Michigan State Medical Society. This year, other Key-men from every county society were invited and an instructional course was given leading to the dissemination of special knowledge on our immediate problems.

This is a move in Public Relationship. The program is listed elsewhere. The Course of lectures was ambitious, attempting to inform these officers and men of the problems and difficulties confronting us, not only through legislation or bureaucratic directive, but by insidious publicity hinting and suggesting changes which would not be for the good of our patients or ourselves.

Measures of this nature are beginning to have some effect. Last month we invited attention to a brochure published and distributed by the Indiana Chamber of Commerce. At Christmas time, the Chamber of Commerce of one of our cities appointed a Committee on Public Health and Welfare, and instructed the Chairman that this question of Socializing of all medical efforts was *their* problem, and not just that of the medical profession; as a matter of fact, they could handle it much more effectively than the medical profession, because of the very nature of the problem.

Early in January in that same city, the night schools of the public high school announced a "People's University" to consist of town hall discussions of several subjects of public and especial interest. Included in the list of topics was "Socialized Medicine." The stimulus to these two moves in aid to a harrassed group is incidental—the fact that such a response was forthcoming is a heartening forebinger of things to come.

But we must not bow our heads, sit back in our chairs, and think the battle is over. It has barely begun, and every battery at our command must move into action. Every member of our society must do his part, and he should see to it that his part is one of inspiration, of accomplishment, and one pointing the way to better things for our patients and ourselves.

CANCER MANUAL

■ THERE has just been placed in our hands a copy of the book, Cancer, published by the Michigan State Medical Society and the Michigan Department of Health. This work of the Cancer Committee represents three years of untiring work and study looking toward the eradication of cancer. The book is two hundred twenty-four pages and covers the subject of cancer from the historical sketch to a classification of cancer and a description of the various forms and kinds of cancer as they attack organs, systems and parts of the body. Heredity, environment, the theories of causation and every conceivable form of approach to the problem of preparing our physicians to cope with the disease are given with the stamp of authority. The list of collaborators speaks for the reliability of the opinions expressed. The prime motive has been the early diagnosis and the prompt removal or suitable treatment of the condition. Every member of the Society should acquire one of these books (it is free to members), and read it carefully. If that is done the Committee will consider its work well repaid, and the Society its money well expended.

WAYNE MEDICAL SCIENCE CENTER

Wayne University is now soliciting funds for its new $50,000,000 Medical Science Center. The site for the new university campus has been announced, just west of Cass Avenue, opposite the public library. The Medical Science Center will be east of the Art Institute, between Brush and Hastings Super Highway, Warren and Ferry, comprising fifteen blocks. The Corporation Council will shortly begin condemnation proceedings for the three blocks immediately needed for the construction of the first unit of the center, the hospital. This will be erected by Wayne County and will serve patients requiring public assistance. Other units physically attached will be the Out-Patient Clinics, and the Hall of the Medical Sciences. These three structures will represent $9,000,000.

To follow as soon as practicable will be the Institute of Industrial Health, $5,000,000. This will be the first institution of its kind, and is fitting for Detroit, the industrial capital of the country. While it will train specialists who intend to devote their lives to industrial medicine, it will also train first-aid men, nurses, safety engineers, and others concerned with industrial health. It will train personnel directors, supervisors, and others who handle groups of men. It will train industrial psychiatrists and industrial researchers. It will study occupational diseases, the utilization of the handicapped and older employes, and all phases of relating the worker harmoniously to his job.

There will also be a Library of the Medical Sciences, The Institute of Continuation Study for postgraduate and extension study of practitioners, an Institute of Biological Research, a Nurses Home, Dormitory for resident physicians, interns and students, a Recreation Center, Power House, Laundry, et cetera. This represents $21,250,000. Thirty millions are desirable for endowment of personnel, research, maintenance, et cetera.

This is a program that has been the hope of Detroit for years, and at last seems a certainty. Wayne University may well be proud of her inspiring outlook in the field of Medicine.

DECLARATION OF MEDICAL POLICIES

THE LAUNCHING of state controlled plans for medical care without consulting the vitally important parties, the Doctors of Medicine, is evidence that the advocates are more concerned with bureaucratic domination than with improving the quality of medical care.

We encourage the presentation of ideas for improvement of medical care by any individual or organization; but any plan of medical care inaugurated without the study and approval of Doctors of Medicine will be considered an unfriendly act.

We, the undersigned, pledge ourselves that in a postwar, free America, we will not accept regimentation of the medical profession.

NAME OF COUNTY MEDICAL SOCIETY	SIGNATURE

If you have not had occasion to sign the Declaration of Medical Policies, do so at once and mail to 2020 Olds Tower, Lansing 8, Michigan.

As an American Citizen

I am opposed to the creation of a costly, unwieldy State Medical bureaucracy to be operated at the taxpayer's expense.



As a Doctor of Medicine

Pledged to American Principles I will NOT COOPERATE with such a bureau.

.....
SIGNED



Pin-up picture for the man who "can't afford" to buy an extra War Bond!

YOU'VE HEARD PEOPLE SAY: "I can't afford to buy an extra War Bond." Perhaps you've said it yourself . . . without realizing what a ridiculous thing it is to say to men who are dying.

Yet it *is* ridiculous, when you think about it. Because today, with national income at an all-time record high . . . with people making more money than ever before . . . with less and less of things to spend money for . . . practically every one of us has extra dollars in his pocket.

The very *least* that *you* can do is to buy an *extra* $100 War Bond . . . above and beyond the Bonds you are now buying or had planned to buy. In fact, if you take stock of your resources, you will probably find that you can buy an *extra* $200 . . . or $300 . . . or even $500 worth of War Bonds.

Sounds like more than you "can afford?" Well, young soldiers can't afford to die, either . . . yet they do it when called upon. So is it too much to ask of us that we invest more of our money in War Bonds . . . the best investment in the world today? Is that too much to ask?

Let's all BACK THE ATTACK

WE BOUGHT EXTRA WAR BONDS
4TH
WAR LOAN

THE MICHIGAN STATE MEDICAL SOCIETY

This is an official U. S. Treasury advertisement—prepared under auspices of Treasury Department and War Advertising Council

COLLECTING BLOOD FOR PLASMA

A state health department traveling unit which is collecting blood from donors for processing into blood plasma in the department's Lansing laboratories visited Charlotte the week of December 30, 1943, and was in Greenville, January 10-14 and in Lansing, January 17-21 and 24-28 inclusive.

Blood plasma already has been supplied to 10 Michigan communities visited by the unit in the closing weeks of 1943. An important use of plasma is in the treatment of shock resulting from accident, surgical operations and burns, and from hemorrhages complicating such diseases as typhoid, dysentery and diarrhea of the newborn. These plasma reserves usually are stored in local hospitals which furnish the plasma, free of charge, to physicians.

A special appropriation voted by the 1943 legislature finances the traveling unit. Local arrangements are handled by Red Cross chapters.

1944 POSTGRADUATE CONFERENCE ON WAR MEDICINE
MICHIGAN STATE MEDICAL SOCIETY

Grand Rapids, September 27, 28, 29

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A. S. Aloe Company, St. Louis....D-13

Baker Laboratories, Cleveland....B-2
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Detroit Creamery Company, Detroit....D-15
Doho Chemical Corporation, New York....D-7

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Gerber Products Company, Fremont, Mich....B-9

Hanovia Chemical & Mfg. Co., Newark....D-9
J. F. Hartz Company, Detroit....D-12, D-14
H. J. Heinz, Company, Pittsburgh....D-20
Hoffman-LaRoche, Inc., Nutley, N. J....E-17
Holland-Rantos Co., Inc., New York....B-15

G. A. Ingram Company, Detroit....C-2, C-4, C-6

Ethicon Suture Division of Johnson & Johnson, New Brunswick, N. J....E-18
"The 'Junket' Folks," Chr. Hansen's Lab. Inc., Little Falls, N. Y....B-13

Kellogg Company, Battle Creek....E-10
A. Kuhlman & Company, Detroit....D-8

Lea & Febiger, Philadelphia....C-10
Lederle Laboratories, Inc., New York, N. Y....E-1
Libby, McNeill & Libby, Chicago....D-22
Eli Lilly & Company, Indianapolis....A-1
J. B. Lippincott Company, Philadelphia....A-6

The Liquid Carbonic Corp., Wall Chemicals Division Chicago....D-5

M & R Dietetic Laboratories, Inc., Columbus, Ohio....C-19
McKesson Appliance Company, Toledo....E-16
McNeil Laboratories, Inc., Philadelphia....E-20
Mead Johnson & Company, Evansville, Ind....B-10, B-12
Medical Arts Surgical Supply Co., Grand Rapids....C-9, C-11, C-12, C-14
Medical Case History Bureau, New York....A-14
Medical Film Guild, New York....A-16 and Cinema Room
Medical Protective Company, Fort Wayne, Ind....C-20
Mellin's Food Company, Boston....E-13
Merck & Company, Inc., Rahway, N. J....B-17
Wm. S. Merrell Company, Cincinnati....E-2
Michigan Medical Service, Detroit....E-22
C. V. Mosby Company, St. Louis....B-11

National Live Stock & Meat Board, Chicago....E-19

Ortho Products, Inc., Linden, N. J....D-11

Parke, Davis & Company, Detroit....D-1, D-3
Pelton & Crane Company, Detroit....D-17
Pet Milk Sales Corporation, St. Louis....C-16, C-18
Philip Morris & Company, Ltd., Inc., New York....B-8
Picker X-Ray Corporation, New York....A-10
Pitman-Moore Company, Indianapolis....E-12
Procter & Gamble Company, Ivorydale, Ohio....C-13
Professional Management, Battle Creek....D-4

Radium Emanation Corporation, New York....E-3
Randolph Surgical Supply Company, Detroit....A-9
Riedel-de Haen, Inc., New York....E-11

W. B. Saunders Company, Philadelphia....A-2
Schering Corporation, Bloomfield, N. J....E-21
Scientific Sugars Company, Columbus, Ind....C-1
G. D. Searle & Company, Chicago....A-3
Sharp & Dohme, Inc., Philadelphia....D-21
Singer Sewing Machine Company, New York....D-2, D-4
Smith, Kline & French Laboratories, Philadelphia....E-4
Spencer Incorporated, New Haven, Conn....C-15
E. R. Squibb & Sons, New York....B-4
Frederick Stearns & Company, Detroit....B-3, B-5

William R. Warner & Company, Inc., New York....D-16, D-18
Westinghouse X-Ray Company, Inc., Detroit....A-15
White Laboratories, Inc., Newark, N. J....B-6
Winthrop Chemical Company, Inc., New York....B-1
John Wyeth & Brother, Inc., Philadelphia....B-14, B-16, B-18, B-20

Zimmer Manufacturing Company, Warsaw, Ind....A-5

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MICHIGAN'S DEPARTMENT OF HEALTH

H. ALLEN MOYER, M.D., Commissioner, Lansing, Michigan

H. ALLEN MOYER, M.D.

1876-1944

Masonic rites were performed in the Congregational Church and at the graveside in Charlotte on Monday, January 10, for H. Allen Moyer, M.D., Commissioner of Health, who died in St. Joseph's Mercy Hospital in Ann Arbor, Thursday, January 6.

Doctor Moyer was appointed Commissioner by the late Governor Dickinson, effective August 1, 1939, and was reappointed by Governor Kelly last July.

A former president of the Eaton County Medical Society and member of the Michigan State Medical Society, American Medical Association and the American Public Health Association, Doctor Moyer as Commissioner of Health had held as his prime objective promotion of active coöperation between private practitioners of medicine and official health agencies in the furthering of public health.

YEAR IN PUBLIC HEALTH IS LARGELY FAVORABLE

Reviewing the record of 1943 in public health in Michigan, the state health department points out that the twelve-month period was largely favorable, no sharp increases in the communicable diseases having been recorded, although diphtheria, meningitis, tuberculosis, measles and the venereal diseases were on the rise as the year ended.

All categories of public health workers were further reduced by the demands of the military services but the year brought extension of organized public health services to an additional three, or a total of sixty-nine of the state's eighty-three counties. The three were St. Clair, Leelanau and Wayne county, outside Detroit. At year's end, 88.5 per cent of the state's population was receiving benefits either of city, county or district health departments.

The department's mobile x-ray unit visited twenty-five counties during the year, examining 37,427 persons for tuberculosis. State subsidies to counties were increased in 1943 to meet rising hospitalization costs for care of tuberculous patients.

Department engineers supervised public health aspects of large construction projects completed in 1943 which brought adequate and safe water supplies and proper sewage disposal facilities to large areas in the southeastern section of the state. The year was the ninth consecutive one in which no case of typhoid fever was attributed to a public water supply.

Deaths in the first 11 months of 1943 totaled 50,423 as compared with a 1942 total of 43,201. Ten leading causes of death were heart disease, again in first place, cancer, apoplexy, accidents, inflammation of kidney, pneumonia, tuberculosis, premature birth, diabetes and hardening of arteries, in that order.

Michigan will set a new record in number of babies born in 1943—an estimated 127,000 on basis of the eleven-month total of 114,433—while holding the infant death rate close to the 1942 all-time low of 37.02 per 1,000 live births.

The state laboratories produced a total of 2,108,159 doses of vaccines, serums and other biologic products during the first 11 months of 1943.

Legislative revision of Michigan's compensation law was partly responsible in 1943 for the adoption by more than 100 industrial concerns of medical programs for their plants. Michigan industries spent approximately $1,800,000 in 1943 in complying with recommendations of the department's bureau of industrial hygiene for improvement of conditions which could adversely affect health of workers. The legislature in 1943, recognizing the increasing need for the bureau's services in a highly industrialized state, approved an increase in appropriation of state funds to $50,000 annually from the $10,000 annually previously allocated to the bureau.

SHARP RISE IS NOTED IN VENEREAL DISEASES

Reported cases of the venereal diseases, particularly syphilis, increased sharply in Michigan in 1943, according to the Michigan Department of Health, 11-month totals for last year exceeding those for all of 1942. In the first 11 months, last year, 14,694 cases of syphilis and 8,782 cases of gonorrhea were reported. Twelve-month totals, 1942 were: syphilis 12,461, gonorrhea 8,753.

State health department laboratories completed more than 1,500,000 blood tests for syphilis last year and seven new clinics were opened, bringing to 34 of the total now being operated as part of the department's control program. Plans are being completed for the establishing of a rapid treatment center which will receive early infectious cases of syphilis and gonorrhea from the state at large.

More than 200,000 venereal disease examinations of persons seeking employment in industry were made last year with the assistance of the Michigan State Medical Society, management and unions. A round-up of Selective Service candidates previously rejected because of venereal disease findings has been undertaken in recent weeks.

A committee representing the state medical society, Michigan Bar association and the department is working to promote the control of the venereal diseases through full application of legal measures.



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PRESIDENT'S INAUGURAL ADDRESS

By Mrs. John J. Walch, Escanaba

In accepting the honor of presidency that you have bestowed upon me, I pledge to fulfill the duties of this office to the best of my ability. In order to maintain the admirable achievements of the past, I must plead for your greatest cooperation and indulgence.



Mrs. J. J. Walch,
President
1943-44

The turmoils of war necessarily alter all activities. The Auxiliary's purpose is to urge its members to continue one hundred per cent registration in all branches of war service. Let us not only maintain last year's enviable record but surpass it if possible. In addition to war participation we must endeavor to retain our organization with its diversified interests, so that it can function uninterruptedly upon the conclusion of the war. The Auxiliary with its 28,000 members has attained a position of national importance. It is considered a reservoir of power—quietly but effectively it enlightens its members to make of them leaders in the progressive thought and action of their communities.

It is vitally important that all county units keep their organization intact—despite decreased membership and fewer opportunities to meet. Keep someone in every office—even if it means that a few women have several positions. It is only in this way that you will be assured of receiving all information released by the Committee Chairmen.

To effect the recommendations of the National President, your Committee Chairmen have thoughtfully prepared a plan of action for you County Presidents to put into use. Our principal work has been completed when, after due consideration, we have agreed on the essential goals for the year and have carefully planned a definite, concise procedure in each department. The result of our work will be evidenced in your execution.

The problem of shifting membership is only one of the incidences of war. Let us encourage our members to maintain membership in their home unit. It will be our duty as well as our pleasure to keep these absent members informed of their county Auxiliary affairs. Let us resolve to extend hospitality and friendship to any members who are temporarily located in our midst in order to make their altered life less difficult.

Presented before Woman's Auxiliary to MSMS, in Detroit, September 22, 1943

Upon recommendation of the National War Participation Chairman, Mrs. Otto S. Hult has been appointed as Michigan State Chairman. Each County President will appoint a War Participation Chairman who will constitute this committee. Their work is the stimulation of war activities, the dissemination of any information emanating from the National office, and the correlation of statistics of the hours of work and types of service all members of the Michigan State Auxiliary have performed. Only in this way can we inform our parent organization as well as the entire country of the concrete worth of our group. As the old adage advises—"Deeds—not words." Mrs. Willoughby has demonstrated to you that every loyal member is now participating in some manner of war work. My request is that you coöperate with your War Participation Chairman and answer promptly all her correspondence.

Our country has need of 60,000 nurses both during and following the war. The supply is alarmingly inadequate. With the approval of the President and the Advisory Council of the Michigan State Medical Society the Auxiliary proposes to inagurate a program to encourage High School graduates to become nurses. After prolonged and involved investigation your Program Chairman, Mrs. G. B. Ohmart, has evolved a very tangible, workable plan that the Medical Society, The Nurses' Association, and many educators of the state are most eager to see expedited. It is within the power of the County Presidents to make or break this most commendable project. All the groundwork possible has been laid for you. You must appoint as your chairman of this committee a woman you are assured will follow through and then you must work with her and keep in touch with her accomplishments. No other organization in this state or no other state of the Auxiliary has attempted this necessary work in the manner and extent that you have here presented you. We have interested so many outstanding people in this project that it is the sincere hope of your administrative officers that you will give this proposal your most loyal support. Contact Mrs. Ohmart while you are here to secure any additional information that you desire. Please report promptly on your appointee and what she has affected in the line of informing school authorities of her services in order that I may present at the National Board meeting in mid-November a report of the project in action.

Our National President urged us to make greater effort in behalf of the distribution of *Hygeia*. It has an especially important part now to play in keeping the public informed since war has increased national interest in questions of public health and has given rise to many new problems for the medical profession to meet. We are advised to see that all USO centers, camps, et cetera, be provided with *Hygeia*. Mrs. Robert

Novy will tell you how to go about the promotion of *Hygeia*. Please, every unit pledge to do more in this department than ever before. Quackery has far more effective propaganda and advertising than the medical profession, so that it is up to us to get what we have into circulation.

Your husband reads the *Journal of the American Medical Association* and his Michigan State JOURNAL. So should you. There are pages in each devoted to the Auxiliary especially. The information contained is of interest and importance to you. Often it is the only means of getting news to you at the right time with the minimum expenditure of time and effort. Co-operate with our Press Chairman, Mrs. Walter Boughner, by sending her promptly and regularly your press clippings.

In order to be well informed as to what the Auxiliary is trying to accomplish, every member should be a subscriber to and reader of the national official publication —namely *The Bulletin*. Its cost is only one dollar a year and there are four issues. All state and county officers absolutely need the *Bulletin* for the competent execution of their duties, for the national chairmen make announcements through this medium now rather than individual letters. Since there is no advertising in this magazine, the subscription list must cover the expenses. The greater the list, the larger the publication can become.

Mrs. Willoughby has very graciously consented to serve as our Public Relations Chairman for the coming year. She will tell you about the Tuberculosis Radio Contest, which proved so successful this year and will provide you with suggestions for the two public relations events or projects each county is to develop during the year. She, however, can only tell you what is available; it is up to you to utilize her findings.

Your program chairman, Mrs. Ohmart, has performed a large share of your Program Chairmen's work for them. She has at her disposal a selection of meeting topics as well as an accumulation of material for their development. Please pay especial attention to the Nurses' Education plan and the request for getting all members informed about the current literature that pertains to the medical profession. This is very important and must be included in every unit's plan of work.

It is your privilege as County Presidents to work with a group of intelligent, educated, far-seeing women. They have evidenced these qualities in conferring on you the honor and responsibility of leadership. A challenging and inspiring blueprint for action has been adopted as the line of march for a year of unparalleled civic achievement. Your chairmen stand ready to render assistance whenever need arises.

Let us, you and I, join hands, and in the midst of the trials and tribulations of war pledge our mutual allegiance to the Woman's Auxiliary to the Michigan State Medical Society.

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IN MEMORIAM

Horatio Alford Brown of Jackson was born November 8, 1881 in Williamsport, Pennsylvania, and was graduated from Rush Medical School in 1909. After serving his internship in Cook County Hospital, Chicago, and taking postgraduate work in New York City, he went to Jackson in 1910 and established a practice. Prominent in local medical affairs, Doctor Brown was a member of the Foote Hospital Board of Managers. He was president of Jackson County Medical Society in 1922 and a past president of Jackson Academy of Medicine and Dentistry. He also served his profession as a delegate to the Michigan State Medical Society. Doctor Brown died on December 10, 1943, in the Good Samaritan Hospital of Lexington Kentucky, while en route to Florida.

* * *

Ellsworth E. Dell of Sand Lake was born September 4, 1871 in Springport, Ontario, and was graduated from the University of Illinois Medical School in 1900. With the exception of a short time spent in the West, he practiced in Sand Lake for forty-two years. He was an honorary member of the staff of Blodgett Hospital in Grand Rapids. He had served on the Sand Lake Village Council and School Board. Doctor Dell was killed in an automobile accident on December 18, 1943.

* * *

John Harvey Kellogg of Battle Creek was born February 26, 1852 in Tyrone, N. Y., and was graduated from Bellevue Hospital Medical School in New York. After graduation he practiced in Battle Creek. He then took over the Battle Creek Sanitarium, putting into effect his own ideas, and in a short time had developed it into a world-famous institution. He was also founder of Miami-Battle Creek, a similar institution at Miami Springs, Florida. In addition to his activities as a health leader, he was a prolific writer. For years he edited the magazine *Good Health,* said to be the oldest health journal in the world. He also invented many medical appliances now in use. Doctor Kellogg was made an Emeritus Member of the Michigan State Medical Society in September, 1939. He died at the age of ninety-one years on December 14, 1943.

* * *

Frank A. Kelly of Detroit was born in 1880 in Alpena, Michigan and was graduated from the Detroit College of Medicine in 1903. He served his internship at Grace Hospital where he remained a member and Chief of the Staff until the time of his death. Twice he went to England at the invitation of the British Medical Association to lecture and conduct clinics in the British Isles. He was recognized in Britain as well as the United States as one of the world's leading authorities in certain branches of surgery. Dr. Kelly's

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Diagnosis, Prevention and Treatment of Tropical Diseases—*6th Edition*

The widespread dissemination of exotic diseases by the return of service men and women from tropical countries and the increased, rapid means of transportation bring new problems to the door of the internist and the general practitioner. This book gives a practical and complete account of tropical diseases, their clinical manifestations, diagnosis and latest methods of treatment. It discusses cosmopolitan diseases encountered in warm countries and tropical diseases that may become endemic in temperate climates. Special attention is given to public health problems relating to the prevention of infectious diseases and to recent investigations on tropical medicine. By Richard P. Strong, M.D., *Harvard Medical School, Emeritus.* 398 Illus., 1826 Pages. 2 Volumes. $21.00.

THE BLAKISTON COMPANY Philadelphia 5, Pa.

engaging personality and his skill advanced him rapidly in his profession. He found time from his regular work to take part in civic activities and to cultivate a large circle of friends. Dr. Kelly also was attending surgeon at Deaconess Hospital, since 1926. He was consulting surgeon at Receiving Hospital and Highland Park General Hospital. He was a member of the State Board of Registration of Medicine in Michigan and served as its president in 1932. He had been a member of the Board of Health since 1939 and was its president in 1941. Doctor Kelly was active in the affairs of the Wayne County Medical Society. At various times, he served as its president, treasurer and trustee. He was a Fellow of the American College of Surgeons. He died on December 10, 1943.

* * *

H. Allen Moyer of Charlotte was born April 12, 1876, in Eaton County and was graduated from the Detroit College of Medicine in 1901. He located in Charlotte where he practiced for thirty-eight years when in March, 1939 he came to Lansing as medical secretary to the late Governor Dickinson, whose personal physician he long had been. On August 1, 1939, he was appointed Commissioner of the State Department of Health, a position he held until the time of his death. Dr. Moyer was a former president of Eaton County Medical Society and a Fellow of the American Medical Association and the American Public Health Association. During his term as Commissioner of Health, the new headquarters of the State Health Department were built and occupied—a model structure throughout the country. Doctor Moyer had been ill several weeks and died on January 6, 1944, in Ann Arbor.

* * *

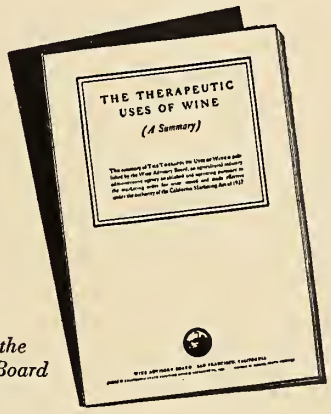
Eryl S. Peterson of Jackson was born February 12, 1883, near Brooklyn and was graduated from the University of Michigan Medical School in 1907. After graduation, he located in Jackson, where he remained until five years ago when poor health caused him to give up his work. He left Jackson to make his home in Florida. Doctor Peterson was a lieutenant in the First World War, past president of the Jackson County Medical Society and a Retired Member of the Michigan State Medical Society. He died November 18, 1943.

* * *

Raymond Duane Sleight of Battle Creek was born July 10, 1875, near Laingsburg, and was graduated from the University of Michigan Medical School in 1897. He practiced one year in St. Johns, then moved to Maple Rapids where he practiced for two and a half years. Doctor Sleight left Maple Rapids to become an instructor in the University of Michigan Medical School, but in 1904 returned to Battle Creek to practice ophthalmology and otolaryngology. In 1908 and 1913, he went to Europe for postgraduate work. During the First World War, Doctor Sleight served in the army medical corps as a captain, first at Camp Sherman and later at Brest, France. He died December 7, 1943.

FACTS DOCTORS SHOULD HAVE ON

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Published by the Wine Advisory Board

DISCUSSIONS of wine's historical uses . . . the caloric content of wine . . . its dextrose and levulose content . . . its vitamin and mineral constituents . . . the assimilability of the ferrous iron in wine . . . etc. . . . form one of the chapters of *The Therapeutic Uses of Wine (a Summary)*. This review in monograph form has been prepared by competent medical authorities. It should be of interest to specialists in many fields as well as to the general practitioner.

THE CONTENTS INCLUDE: Sections on the actions of wine on the gastro-intestinal system, the cardio-vascular system, the kidneys and urinary passages, the nervous system and the muscles, and the respiratory system. The uses of wine in diabetes mellitus, in acute infectious diseases and in treatment of the aged and the convalescent. The value of wine as a vehicle for medication. The contraindications to the use of wine. And an extensive bibliography for those who may wish to pursue the subject further.

This review results from a study supported by the Wine Advisory Board, an agricultural industry administrative agency established under the California Marketing Act, and has been sponsored by the Society of Medical Friends of Wine.

A copy of *The Therapeutic Uses of Wine* is available on request to any member of the medical profession. Write for it, to the Wine Advisory Board, 85 Second Street, San Francisco 5, California.

Say you saw it in the Journal of the Michigan State Medical Society

CORRESPONDENCE

January 5, 1944

To The Editor

Dear Dr. Haughey:

At the October meeting of the Allegan County Medical Society, they made me chairman of a committee in regard to the Wagner Bill. The more I think about this matter, the more it seems that we will have to proceed in the way we have always done in the past —try to save the lives of others. We are not the only ones being regimented, but few seem to realize what is going on in our country.

Of course, it is a popular thing among people to think that they would have their medical care given to them. In this cradle to the grave talk, something for nothing, they do not stop to think that the 12 per cent of the annual income of this country, which in the end would probably be only a small part of the expense, would have to be paid out of their own pockets. So I feel that the best approach to this subject is in arousing the public to the regimentation that is going on in all the lives of our country.

Some months ago I had a patient so ill we could not move him to a hospital. We were in great need of a trained nurse. We tried up and down western Michigan but could find none. In our extremity, we called one of the hospitals in Grand Rapids, where a girl was in training who had formerly worked for this family. The Superintendent was asked if she would release this nurse for two or three weeks for this emergency. No, she replied, she is in the army and we are not allowed to release anyone.

A few weeks ago, in Ann Arbor, a student nurse told me she had just received her first check from the government, and that she was a cadet now in the army. Her sister was also taking training in the University Hospital and she was also in the army. All the medical students, I understand, are getting $50.00 a month and, if married, their wives get a like amount. They are in the army. We will soon have ten million men in the army. They will be fairly well regimented.

Last summer, one of our leading farmers met with other men on a committee where a federal man from Washington began to order their ways of farming, what they could raise and what they were not allowed to produce. These farmers became so indignant at the orders this man was handing out that they finally "got up on their hind legs" and told him "where to get off," and he was obliged to "haul in his horns." Not, however, until he had revealed a blueprint as to how the government was planning to regiment the agricultural life of this country.

The labor unions present another group that is pretty well regimented as far as their vote power is con-



cerned. Also, we have a large army of welfare people who are being well looked after. The agents are busy looking up independent people, telling them they should be getting pensions, and they usually do not have to urge people very much before this Santa Claus gift is accepted. Thus, here is another large group, when it comes to its voting power. Also, we have an army of office and job holders up and down this country and, of course, they would be most loyal to this regimentation when it comes to voting.

So it appears to me that our best approach to publicity is by exposing the cunning methods of this administration that is leading us into a completely regimented country. It was with this in mind that I sent the enclosed letter to each U. S. Senator. So far, thirty-four have replied; of these eleven were noncommittal. The others were decidedly opposed to the regimentation of physicians. Some of the best answers came from the Democratic side of the Senate. Letters from Senators Byrd, Tydings, George, Clark and Pepper were among the best sent. They were decidedly against this Wagner Bill.

You, of course, probably have a complete line of what is going on down in Washington, but I thought that you might be interested in that at least two-thirds of the Senators who answered my letter were decidedly opposed to this regimentation. These letters are on file with our County Society's secretary.

Very sincerely yours,

EUGENE T. BRUNSON

* * *

DR. BRUNSON'S LETTER TO THE SENATORS

October, 1943

Dear Senator:

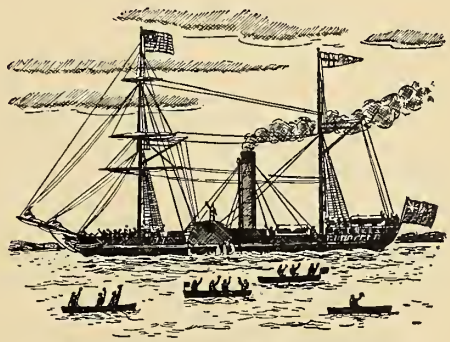
Representing the Allegan County Medical Society, it has fallen to my lot to write you in regard to Senate Bill S.1161.

For many years there has been a movement on foot, especially of late, to socialize medicine. It seems to be a pet theory of many people to cure the ills of mankind by having all the bills paid with other people's money.

There has been a rampant parade of these socialistic, self-appointed, so-called philanthropic welfare people, that seem to blame the doctors for all the misfortunes that befall the human race. Little credit is given to his life-saving efforts; his unselfish and sacrificial gifts to society. And the idea now is that he is no longer to be independent, but rather a slave to the beckoning of all, with incomes set at the pleasure of others, no matter how long the hours or arduous the labor.

It would appear that it is but one of the many lines of changes being sought by these termites working at the foundations of our government. It will be equally in order to have all the dentists, the lawyers, the engineers, the druggists, the teachers, the schools, and all private enterprise socialized. Then when we have a few more added, why not turn the whole nation over to

The Ship is different today...

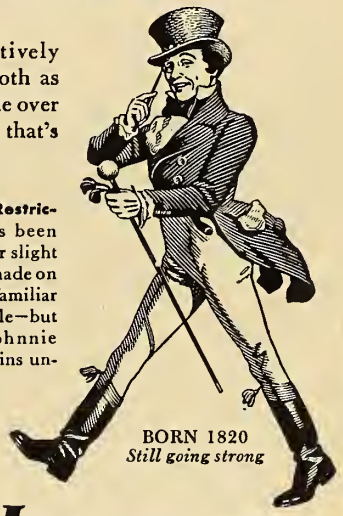


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Sole Importer
BUY UNITED STATES WAR BONDS AND STAMPS

The Chicago Medical Society's Annual Clinical Conference

Stevens Hotel, March 14, 15, 16, 17

Because of the added work imposed on physicians by the war, an intensive post-graduate conference is being arranged. The various subjects will be presented in the most practical way so as to be of immediate assistance to physicians in their daily practice. Men in service, as well as distinguished leaders in civilian practice, wil take part in the program.

Wednesday evening will be given over to a banquet addresed by a non-medical man on a subject of interest to the ladies as well as to the physicians.

Final programs will be mailed to every physician in the state.

Registration fee $5.00.

Hotel reservations should be made early.

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Stalin or his successor. America is indeed rapidly becoming no longer America.

In this hour, when the leader of this nation is so drunk with power, that he no longer respects the laws and desires of the people, why should we as a nation, be blind to the facts? Where is our American blood? Where are the true Americans that will fight for the land of Washington and Lincoln? Are they all dead or dying? Have we only weaklings in Washington to stand for our rights; to fight for our most precious heritage? Heaven have mercy upon us if we fail to have leaders to save our nation in this terrible hour of danger and incompetency!

Will you kindly let me know your intentions and attitude as to this regimentation of medicine, and all the other false philanthropies that have been tried out in other countries with failure?

Very sincerely yours,

EUGENE T. BRUNSON

Mr. Frank E. Atkins, Jr.
20045 Glastonbury,
Detroit, Michigan

Dear Sir:

I have before me your letter dated December 17, and addressed to the Michigan Department of Health, in which you ask whether or not a Red Cross or First Aid Assistant can legally administer adrenalin directly to the heart by means of a hypodermic needle.

The answer to your question is NO. I am sending you a copy of the Medical Practice Laws of Michigan, Act 237, Public Acts of 1899, and suggest that you refer to Section 9, in which the practice of medicine is defined.

Yours very truly,

J. E. MCINTYRE, M.D., *Secretary*

December 23, 1943

PHYSIOLOGIC NONSENSE

"Since the demonstration of the value of the treatment of poliomyelitis described by Miss Elizabeth Kenny," *The Journal of the American Medical Association* for January 22 says, "studies have been made in an attempt to explain the physiologic and pathologic conditions associated with the observed effects. The adherents of the Kenny theory have asserted that the harm of infantile paralysis is due to 'spasm' of the affected muscles rather than to a flaccid paralysis. Qualified investigators have shown that this is not the case. As stated recently by Stanley Cobb, it is being demonstrated once more in the history of medicine that new and empirical methods of treatment backed by uncritical enthusiasm may produce many cures but much physiologic nonsense. The treatment may be good, but the *ex post facto* conclusions of the therapeutist are usually bad."

Say you saw it in the Journal of the Michigan State Medical Society

COUNTY AND PERSONAL ACTIVITIES

Since Pearl Harbor, 800,000 Army-Navy men have been discharged—mostly minor disabilities.

* * *

The Bulletin of the Calhoun County Medical Society reports that the name of the Calhoun County Public Hospital has been changed to the "Arthur S. Kimball Sanitorium."

* * *

"Japanese Medicine," an interesting and illuminating article by H. E. Randall, M.D., Flint, appeared as a feature article in the *Bulletin of the Genesee County Medical Society,* January 11, 1944, issue.

* * *

Reed M. Nesbit, M.D., and *Robert H. Cummings, M.D.,* Ann Arbor, are authors of an original article "Prostatic Carcinoma Treated by Orchiectomy," which appeared in JAMA of January 8, 1944.

* * *

The American Red Cross will raise its 1944 War Fund during March. A goal of $200,000,000 has been set. This must be met if the Red Cross is to continue its work on an undiminished scale. Let's give!

* * *

Among flight surgeons in the Pacific, pictured in JAMA of January 1, were 1st Lieut. Allen P. Newman, of Carleton, Michigan, and Capt. Bernard J. Goldman, Detroit.

* * *

A. B. Thompson, Sr., M.D., was the recipient of the gold-headed cane which is presented to the oldest physician in practice by the Kent County Medical Society. The presentation was made at the 41st Annual Meeting of the Society on December 14, 1943.

* * *

Joseph W. Planck, L.L.B., of Lansing, was guest speaker at the Annual President's Night of the Ingham County Medical Society, Olds Hotel, Lansing. T. I. Bauer, M.D., presided and introduced Mr. Planck who spoke on "Law, Medicine and World Peace."

* * *

THE COVER

Administrating blood plasma to a wounded soldier at a Portable Hospital located somewhere in New Guinea is pictured on the cover of this number of THE JOURNAL.

Carey P. McCord, M.D., of Detroit, is co-author of a special article "Dangers of Methyl Chloride as Substitute for Freon: A Statement by the Association's Committee to Study Air Conditioning" which appeared in JAMA of January 8, 1944.

* * *

"Approximately 12,000 graduates of recent years are serving in the armed forces whose previous training in civilian hospitals did not extend beyond the intern year." —AMA Council on Medical Education and Hospitals. JAMA, January 1, 1944, Page 40.

* * *

David Littlejohn, M.D., Health Officer of Chippewa County and Sault Ste. Marie for a number of years, has accepted the post of Health Officer of Wayne County. Congratulations, Doctor Littlejohn, and full success in your work!

* * *

The American Board of Ophthalmology's Executive Office is now located at P. O. Box 1940, Portland 2, Maine. S. Judd Beach, M.D., is Secretary-Treasurer.

The 1944 examinations of the Board will take place in New York on June 3 and 4 and in Chicago on October 5, 6, 7.

* * *

L. Fernald Foster, M.D., Bay City and *William J. Burns,* Lansing were discussants of "Hospital Plans in Indiana," which was presented by Charles N. Combs, M.D., of Terre Haute, at the Indiana State Medical Association Secretaries' Conference, Indianapolis, January 23.

* * *

Federal bureaucracy: More than 3,300,000 civilians are on the payroll of the United States Government.

It is encouraging to note that the Byrd Committee on Excessive Federal Expenditures is working on reduction in U. S. Bureau personnel. This will be done in the appropriation bills for the fiscal year 1945, on which the House of Representatives is now working.

* * *

COMING MEETINGS

Northern Tri-State Medical Association, Toledo, April 11, 1944. American Medical Association, Chicago, June 12 to 16. Michigan State Medical Society, Grand Rapids, September 27, 28, 29.

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Jonas E. Salk, M.D., Wilbur J. Menke, M.D., and *Thomas Francis, Jr., M.D.,* of Ann Arbor, Michigan, are authors of an original article, under Clinical Notes, Suggestions and New Instruments, which appeared in JAMA of January 8. The paper is entitled "Identification of Influenza Virus Type A in Current Outbreak of Respirator Disease."

* * *

The National Conference on Medical Service, an important medical-economic meeting, was held Sunday February 13, Palmer House, Chicago. Representatives of the Michigan State Medical Society to this Conference were C. R. Keyport, M.D., Grayling, V. M. Moore, M.D., Grand Rapids, L. Fernald Foster, M.D., Bay City, Wilfrid Haughey, M.D., Battle Creek and Wm. J. Burns, Lansing.

* * *

President Eric A. Johnston of the Chamber of Commerce of the United States announced today the appointment of Leverett D. Bristol, M.D., executive director of the Hospital Council of Greater New York, as chairman of the Chamber's Health Advisory Council and Anthony J. Lanza, M.D., chief of the Occupational Hygiene Section of the Office of the Surgeon General, U. S. Army, as chairman of the Council's Committee on Industrial Health.

* * *

The one-hundred spaces in the Technical Exhibit of the 1944 Postgraduate Conference on War Medicine—the 79th Annual Session of the Michigan State Medical Society—were all reserved within two weeks after the Prospectus was mailed on December 18, 1943.

A list of the 1944 Technical Exhibitors, indicating the names of many old and some new friends of the Michigan medical profession, is published in this issue of THE JOURNAL.

* * *

R. E. Hayes, M.D., of Sagola, Michigan, was honored at a community party on the occasion of his fortieth anniversary in the practice of medicine. Upwards of 350 persons were present to honor Dr. Hayes. Eulogies were expressed, on behalf of the Dickinson-Iron Medical Society, by W. H. Alexander, M.D. and D. R. Smith, M.D. of Iron Mountain. A gift of $200 to purchase a "needed fish pole" was presented to Dr. Hayes.

* * *

"Today the U. S. bureaus are nonpolitical.—They owe allegiance to no party. They are affected by no elections. They are not controlled by the will of the public. Yet they are one of the strongest single political influences in the nation, throwing the weight of their huge voting power not necessarily in support of those candidates of either party that are striving to carry out the mandates of the voters, but in support of those who will sustain them in their bureaucratic security and who will not disrupt their organizations."—GOVERNOR HERBERT B. MAW, Utah.

* * *

Health insurance in the United States has reached the point where hospital insurance now covers 13,000,000 on a Blue Cross Plan and is operating in thirty-six of the forty-eight states, according to N. Sinai, Dr.P.H., Ann Arbor.

About 4,000,000 more are covered by commercial plans for hospital insurance.

Some 800,000 have insurance for medical care under plans sponsored by medical societies in twelve states and there are hundreds of industrial plans covering all varieties of health insurance.

* * *

Directory of Medical Specialists. A supplemental list of all those who have been certified by the American Boards since the last edition of the Directory (1942), totalling about 3,600, will soon be published by the Advisory Board for Medical Specialties. This will be distributed at cost, and monthly or bi-monthly bulletins listing successful candidates for certification at examinations during the additional interim before the next edition (1945), are to be issued as a subscribers' service. The address of the Directing Editor is 919 N. Michigan Ave., Chicago 11, Illinois.

* * *

Electric Refrigerators Available.—The War Production Board has made available on priority electric refrigerators for public health needs. These can be bought only by doctors, laboratories and hospitals for the storage of vaccines, serums, biologicals and blood plasma.

Word has been received that the Electrical Appliances Department of the J. L. Hudson Company in Detroit has a selection of 18 different models. They will be glad to help any health officer with his selection if he needs a refrigerator and will assist in filling out the priority application.

* * *

Freedom of Enterprise.—In contradiction to Miss Frances Perkins, there is only one lesson we are able to draw from all these facts. Boiled down, it goes like this:

A broad Social Security system on a compulsory basis and under federal control ties up the financial resources of the nation so effectively that there is small room and little attraction for private enterprise.

The four freedoms pronounced by President Roosevelt have little practical meaning unless a fifth freedom is added: Freedom of Enterprise. But free business enterprise and expanded industrial production will find it difficult to operate at full tilt, with a broad system of Social Security siphoning off from $10 billion to $15 billion each year.—GERHARD HIRSCHFELD, Insurance Economics Society of America.

* * *

E. B. Andersen, M.D., secretary of the Dickinson-Iron County Medical Society, reports in his annual Secretary's Report that his small group (twenty-two members) held ten regular meetings during 1943. The average attendance was 75 per cent. This is an exceedingly high percentage of attendance for these busy wartimes.

An important statement in his report reads as follows: "Too Little and Too Late: One important lesson we should learn from the obstetric-pediatric pro-

gram is that it is too late to forestall or influence a service program if we wait until it has been written into the acts of Congress."

* * *

New Fellows of the American College of Surgeons include these physicians from Michigan: Wilbur Max Brown, Detroit; Richard J. Brown, Owosso; Brock E. Brush, Detroit; Darrell A. Campbell, Ann Arbor; Luther C. Carpenter, Jr., Grand Rapids; William S. Carpenter, Detroit; Ennis H. Corley, Jackson; J. Brown Farrior, Ann Arbor; Herbert B. Gaston, Detroit; Harold W. Gehring, Detroit; W. Merideth Green, Pontiac; Edwin J. Hammer, Grosse Pointe; Charles M. Henry, Detroit; Charles P. Hodgkinson, Detroit; Donald H. Hooker, Detroit; Francis A. Jones, Jr., Lansing; Elmore F. Lewis, Jackson; Dugald S. MacIntyre, Ann Arbor; M. Mozart Marrin, Jr., Grand Rapids; C. Rex Moe, Kalamazoo; George J. Moriarty, Jr., Detroit; Paul V. O'Rourke, Detroit; John P. Ottaway, Detroit; George T. Riggs, Detroit; Alexander W. Sanders, Detroit; Arthur E. Wentz, Birmingham.

* * *

The official personnel of all Branch and Special Societies in Detroit and Wayne County was published in the January 10 *Detroit Medical News*. The Societies listed were: Dearborn Medical Society, East Side Medical Society, Highland Park Physicians Club, West Side Medical Society, Southern Division of the Wayne County Medical Society (all official branches of the Wayne County Medical Society), Blackwell Medical Society, Detroit Academy of Medicine, Detroit Academy of Surgery, Detroit Branch of American Neurological Society, Detroit Dermatological Society, Detroit Medical Club, Detroit Medical Society, Detroit Ophthalmological Society, Detroit Otolaryngological Society, Detroit Pediatric Society, Detroit Roentgen Ray and Radium Society, Grosse Pointe Medical Club, Maimonides Medical Society, Medical-Dental Arts Club, Michigan Orthopedic Society, Michigan Society of Neurology and Psychiatry, Michigan Society of Industrial Physicians and Surgeons, Michigan Society of Obstetricians and Gynecologists, Detroit Pathological Society, The Seniors Club and the Woman's Auxiliary.

* * *

School of Physical Medicine.—The establishment of the first center for the scientific study and development of physical medicine as a branch of medical practise has been annnounced by Basil O'Connor, President of The National Foundation for Infantile Paralysis. The center will be in the Graduate School of Medicine of the University of Pennsylvania at Philadelphia.

To set up this center The National Foundation for Infantile Paralysis has made a grant totaling $150,000 for a five-year period from January 1, 1944.

The Center for Research and Instruction in Physical Medicine will include:

1. A center for development of physical medicine as a scientific part of the practice of medicine.
2. A training center for medical leaders and teachers in this branch of medicine, and
3. A school for training technical workers under

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MEDICINE—Two Weeks' Course Gastro-Enterology starting June 5. Two Weeks' Intensive Course Internal Medicine starts June 19.

GYNECOLOGY—Two Weeks' Intensive Course starting February 7 and April 3. One Week Personal Course Vaginal Approach to Pelvic Surgery starting April 17.

OBSTETRICS—Two Weeks' Intensive Course starting February 21 and April 17.

ANESTHESIA—Two Weeks' Course Regional and Intravenous Anesthesia.

GASTROSCOPY—Personal Course starting April 3, June 19, and October 16.

OTOLARYNGOLOGY—Two Weeks' Intensive Course starting April 3.

ROENTGENOLOGY—Courses in X-ray Interpretation, Fluoroscopy, Deep X-Ray Therapy every week.

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the guidance of such professional and scientific leadership, such a school to be only incidental to and dependent upon the first two purposes.

* * *

Afflicted-Crippled Children.—1. In Afflicted-Crippled Children cases, where physicians do not accept the surgical or medical fee of the Commission, they must make previous arrangements with the patient in writing and a notification of the fact that such arrangements have been made must be sent to the Commission so that both patient and the Commission are informed that the Michigan Crippled Children Commission medical fees will not be accepted by the doctor.

2. Bills for dangerous contagious diseases are payable by the county. If they are sent to the Commission they will be charged back to the county.

3. The Commission will accept billing for services of only one physician on each case, with the following exceptions:

(a) when consultation is necessary;

(b) when the services of a surgeon who is not the attending physician are required, the attending physician will be allowed fees for bedside care in accordance with schedule of fees prior to operative date, and the surgeon will be allowed the surgical fee, to include after-care for a thirty-day period.

Two hundred dollars shall be the maximum paid for medical and surgical fees for any one patient in any one year, under Act 158 of the P. A. 1937, and under Act 283 of the P. A. of 1939.

4. Prompt and correct billing: while the penalty imposed on hospitals for delayed reporting of admittances of Afflicted-Crippled Children does not affect billing for doctors' services, *it is the physician's responsibility to see that the hospital sends a correct bill for his services to the Commission.* The physician should submit his statement on his own billhead to the hospital before the end of the calendar month in which the service took place. *Billings delayed over sixty days after the patient leaves the hospital will not be paid.*

* * *

FILING A BIRTH CERTIFICATE BY ATTORNEY-IN-FACT

The question whether an attorney-in-fact may file a birth certificate in behalf of a physician who attended the birth but is now in overseas service is answered in a ruling of Michigan's Attorney General, dated November 23, 1943, which is as follows:

"It is the opinion of this office that the attorney-in-fact has no authority to sign a birth certificate under such circumstances. It appears very definitely from the statute, Section 6584, Compiled Laws of 1929, Section 14.232, Michigan Statutes Annotated, that the certificate must be filed by one having personal knowledge of the birth and in attendance thereat. Act 35, Public Acts of 1931, being Section 14.271, Michigan Statutes Annotated, makes provision that where a birth cannot be recorded under the above-mentioned statute application for the registration of the birth may be made by *the interested person* to the Judge of Probate, etc. A former opinion of this office, given July 6, 1942, No. 24120, concludes that the words underlined above referred, in substance, to any interested person and

Say you saw it in the Journal of the Michigan State Medical Society

that a mother may make application to have the birth of her deceased son recorded.

"It follows that the parents of the child here in question may establish the birth of the baby under said Act 35, Public Acts of 1931."

* * *

"1944 DUES—DONATION OR INVESTMENT"

"Members of the State Medical Society of Wisconsin will pay dues of $33 for the calendar year of 1944. The reference committee of the House of Delegates which proposed dues in this amount stated to the House that this action was needed because "the medical profession is confronted with problems with reference to the pending proposals for the change of the economic system under which the individual physician would be able to engage in practice, and particularly the need for the further and wider dissemination on the state level of information to the public concerning these vital projects" and the need that exists "to protect the integrity of the medical profession for the men in service as well as those who remain on the home front, because of the probability that confronts the organized medical profession that the war effort will demand the enrollment of a greater number of physicians than are represented in the armed services at the present time.

"When members of the Society appreciate that there are now in excess of 800 Wisconsin physicians in military service, that the problems of the times are complex and of a variety never before encountered, and that the services of the Society to the public health of the people of this state are almost limitless, it does not seem that there will be many who will raise the question of whether dues are a donation or an investment." —Editorial in *Wisconsin Medical Journal.*

* * *

ANNUAL CLINICAL CONFERENCE INAUGURATED BY CHICAGO MEDICAL SOCIETY

The Council of the Chicago Medical Society, appreciating that Chicago is a medical center offering abundant clinical material and able clinicians, is sponsoring an Annual Clinical Conference at the Stevens Hotel, March 14, 15, 16 and 17.

Plans have been made for four intensive Postgraduate Days consisting of half-hour lecture and clinic periods beginning at 8:00 a.m. and continuing until 5:30 p.m. each day with intermissions for luncheons and inspection of technical and scientific exhibits. Several one hour "Panels" have been arranged. Popular subjects will be covered by specialists in their respective fields.

A dinner will be held on Wednesday evening with a speaker of national reputation on some nonmedical subject.

The Chicago Medical Society believes such a four-day conference will be helpful as a wartime measure to its members and to the profession of the Middle West. All scientific sessions will be held in the Grand Ballroom of the Stevens Hotel. Registration fee will be $5.00.

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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

CLINICAL AUDIOMETRY. By C. C. Bunch, M.A., Ph.D. Formerly Associate Professor of Otology, Medical School, University of Iowa; Associate in Research Otology, Johns Hopkins University; Professor of Applied Physics of Otology, School of Otology, School of Medicine, Washington University; Associate Director of Central Institute for the Deaf, St. Louis; Research Professor in Education of the Deaf, School of Speech, Northwestern University. With Seventy-four Text Illustrations. St. Louis: The C. V. Mosby Company, 1943. Price $4.00.

Professor Bunch spent many years in research in hearing, measuring the losses, and diagnosing the defects. This book of 186 pages is full of his findings. The history of the tuning fork tests for the measuring of hearing loss is given, the meaning of the Weber Test, first described in 1834, the Rinne Test (1885), and the various tuning fork tests are given in detail, with the reasons and meaning. The modern audiometer is described, its history and standardization and use. The records taken are studied and their interpretation given in considerable detail. The science of audiometry is growing by strides and the interpretation of the findings is given with as much clearness as our present knowledge warrants.

An Otologist cannot be without this book if he wants to be abreast of his art.

PERSONAL AND COMMUNITY HEALTH. By C. E. Turner, A.M., Sc.D., Dr.P.H., Professor of Public Health in the Massachusetts Institute of Technology; formerly Associate Professor of Hygiene in the Tufts College Medical and Dental Schools; Sometime Member of the Administrative Board in the School of Public Health of Harvard University and the Massachusetts Institute of Technology. Seventh Edition. St. Louis: The C. V. Mosby Company, 1943. Price $3.50.

This is a textbook on health and hygiene written for the more advanced student of college age. Those students will enter some calling or profession where a knowledge of personal health and hygiene will be invaluable. They should acquire a standard that will enable them to meet the requirements of the work place, the home and the community. The material has been selected from that used in many years of instruction of students in public health, medicine, dentistry, engineers, teachers, nurses, etc. Throughout the animal world, except man, early death is the rule and adult life the exception. This was true in man not so long ago. In colonial times the average life expectancy of a baby was 29 years, now it is about

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64. This is the result of public and private health and hygiene education. Personal and public health cannot be separated completely, but the first half of the book is devoted to the personal question covering anatomy and physiology, hygienic rules, diet, vitamins, nutrition digestion, oral hygiene, respiration, the circulation, care of the skin, hair, sense organs, mental hygiene, care of the feet, the nervous system, heredity and reproduction.

The section on Community health covers disease prevention, the three great plagues: tuberculosis, syphilis and the common cold; also water supply, sewage disposal, ventilating, heating and lighting, school hygiene, and an appendix summarizing and giving a quite complete description of the communicable diseases. This is a seventh edition, and is well up to standard, well written and a fine sample of the bookmaker's art.

BODY POISE. By Walter Truslow, M.D., F.A.C.S., Consulting Orthopedic Surgeon to the following hospitals: Brooklyn, Long Island, St. John's, Norwegian, Victory Memorial, Evangelical Deaconess, Kingston Avenue, St. Giles, Brooklyn, N. Y., and Pilgrim State, Brentwood, N. Y.; former Lecturer on Orthopedic Surgery, Long Island Medical College, and on Anatomy and Kinesiology, New York University, et cetera. Baltimore: The Williams and Wilkins Company, 1943. Price $4.50.

The war and the conditioning of soldiers has brought to attention the business of body training, the science of developing the proper and most efficient body poise. The malformation of bones and joints, the improper use or abuse of muscle combinations may render the body poise such that the individual loses his best efficiency, and may lead to deformity. To correct these faults is a useful and important part of military training, of athletic development, and should be a part of the training of all young people. To understand what can be accomplished, and to render the training needed, it is necessary to study the body framework, the musculature, the muscle groups and their functions. The purposes of certain exercises and when and how to apply them is the function of this book. Dr. Truslow is eminently qualified to present this study which emphasizes the work of the orthopedist and the physical education director. Pictures are given of bone groups, muscles, and postures and exercises used in corrective procedures. A chapter is given of the effects of body poise on games, and their effects on body poise. Some are good posture building, and some present mild tendency to faulty body poise. The book is beautifully executed, good paper, type and 312 pages of readable and excellent text.

PRINCIPLES AND PRACTICE OF REHABILITATION. By John Eisele Davis, M.A., Sc.D., Veteran's Administration Facility, Perry Point, Maryland. New York: A. S. Barnes and Company, 1943. Price $3.00.

The question and problem of rehabilitation of patients from our Psychiatric institutions has been a growing one. During the fiscal year ending June 30, 1942, 21,755 were rehabilitated while 55,051 were in the process. That gives the magnitude of the work. This will be much increased as the result of this war, where thousands are being rejected or discharged from the

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AMERICAN REVIEW OF SOVIET MEDICINE. New York: American Soviet Medical Society, October, 1943. 130 W. 46 St., New York 19.

This is the first number of a medical journal which is to publish translations and reviews of the writings and work of medicine under the Soviet Union. We are unable to determine whether this is monthly, or what the period of publication is. A society has been formed under the presidency of Dr. Walter B. Cannon, Professor Emeritus of Harvard University. The Editor is Dr. Henry E. Sigerist, Director of the Institute of the History of Medicine, Johns Hopkins University. The first number contains an article by E. I. Smirnov on the Organization of the Medical Care of the Wounded in the Red Army Medical Corps; an article on the Effect of Frostbite on the Sympathetic Nervous System by Nikolai N. Burdenko, Chief Surgeon of the Red Army; an article on the Time Element in Restorative Surgery of Peripheral Nerve Lesions by V. V. Lebedenko; one on Nerve Transplantation, and an article on Spasokukotski's Method of Feeding Abdominal Wounds. These are all very interesting, and contain many far advanced ideas. There is an article on Physical Culture in the Soviet Union and an editorial on the twenty-five years of Health work in the Soviet Union, describing the practice in the U.S.S.R. Two short statements are of interest. "The Commissariats produce the medical personnel they need . . . They are in charge of educational institutions . . . Medical students have a five-year course which is supplemented by three years spent in rural practice" and "in 1942, the accelerated program was abandoned because it was found that a competent physician cannot be trained in less than the normal time."

SURGICAL ERRORS AND SAFEGUARDS. By Max Thorek, M.D. Foreword by Sir Hugh Devine, FRCS, and chapter on Legal Responsibility in Surgical Practice by Hubert W. Smith, M.D., Harvard Medical School. 4th ed. 1048 pages. Philadelphia: J. B. Lippincott Company, 1943.

The surgical profession will welcome this new enlarged fourth edition of a familiar and generally accepted text first published in 1932. The author has added a chapter on errors and safeguards in plastic operations, another chapter on errors and safeguards in electro-surgical operations and an excellent section by Dr. Hubert Smith on Medico-legal aspects of surgical practice. There is a wealth of material drawn from the author's wide experience with added clinical cases and experiences of surgeons throughout the world.

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The book is profusely illustrated, and the descriptive anatomy and clinical pathological material is particularly good. There are numerous x-ray plates, and the use of the sulfonamides and blood plasma is well handled.

General measures of pre-operative and postoperative care which minimize the risk of surgery and contribute to the patient's recovery have been thoughtfully dealt with, as well as measures to be taken when unusual conditions or accidents confront and perplex the operating surgeon. Dr. Thorek disagrees with a current trend to get the surgical patient out of bed early. Errors in diagnosis as well as errors in treatment are dealt with in detail. Unusual cases, rarely encountered, but unique problems when discovered, play an important part in the discussions. Anomalies, usual and unusual, receive their proper attention, and the ordinary accessory organs and structures are described. The author has a wealth of diagnostic signs and procedures which will aid the inexperienced as well as the experienced surgeon.

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Baker Laboratories 159
Barry Allergy Laboratories 125
Blakiston Company 162
Borden Co. 99
Burroughs-Wellcome & Co. 104, 105

Camel Cigarettes 103
Camp, S. H., & Co. 101
Canada Dry Ginger Ale, Inc. 165
Central Laboratories—Detroit 170
Central Laboratory—Saginaw 173
Cheplin Biological Laboratories, Inc. 107
Chicago Medical Society 166
Ciba Pharmaceutical Products 121
Insert, facing page 112
Clinical Laboratories 174
Coca-Cola Co. 164
Cook County Graduate School of Medicine 170

DeNike Sanitarium 172

Ferguson-Droste-Ferguson Sanitarium 169

Hack Shoe Co. 127
Hotel Olds 174

Ingram, G. A., Co. 113

Kurt Co., The 111

Lederle Laboratories, Inc. 119
Lilly, Eli, & Co. 128

M. & R. Dietetic Laboratories, Inc. 109
Mead Johnson & Co. ..... Back Cover
Medical Protective Co. 173
Milwaukee Sanitarium ..... Back Cover

Ortho Products, Inc. 176

Parke, Davis & Co. 123
Philip Morris & Co. 124
Physicians Casualty Association 166
Physicians Service Laboratory 174
Pogue, Mary E., School 174

Randolph Surgical Supply Co. 157
Rupp & Bowman Co. 175

S.M.A. Corporation ..... Inside Front Cover
Schmid, Julius, & Co. 126
Spencer, Inc. 161
Squibb, E. R., & Sons 115
Stearns, Frederick, & Co. 97
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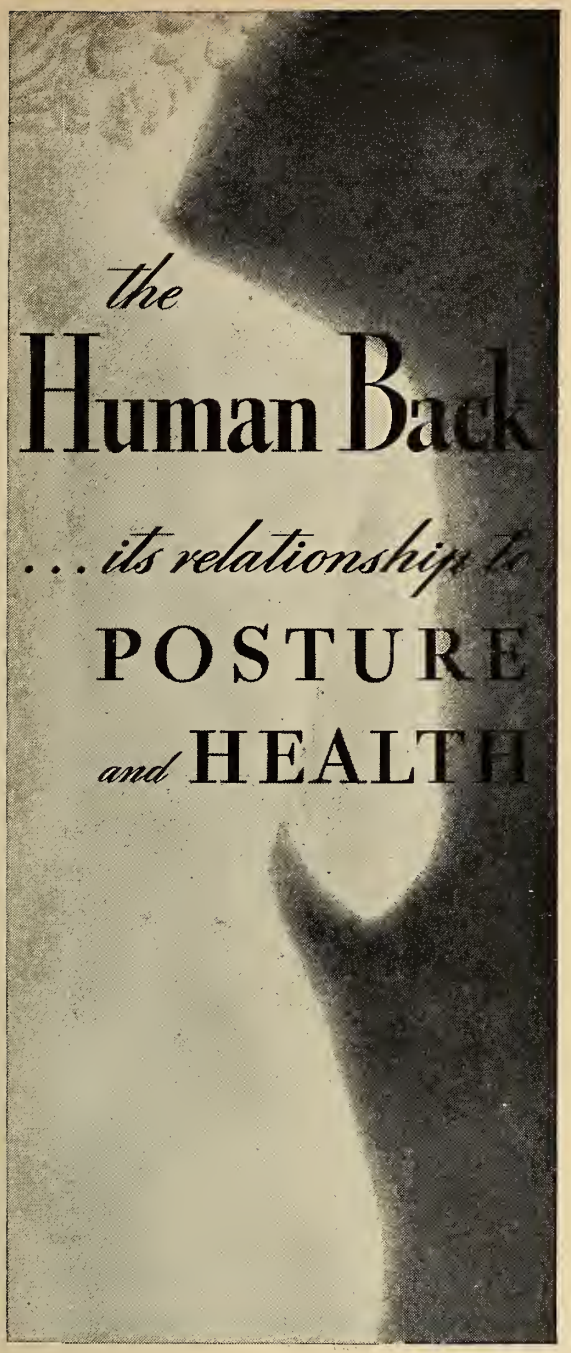
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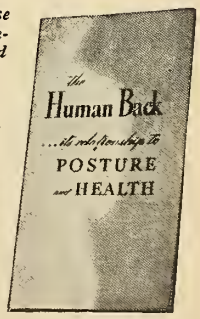
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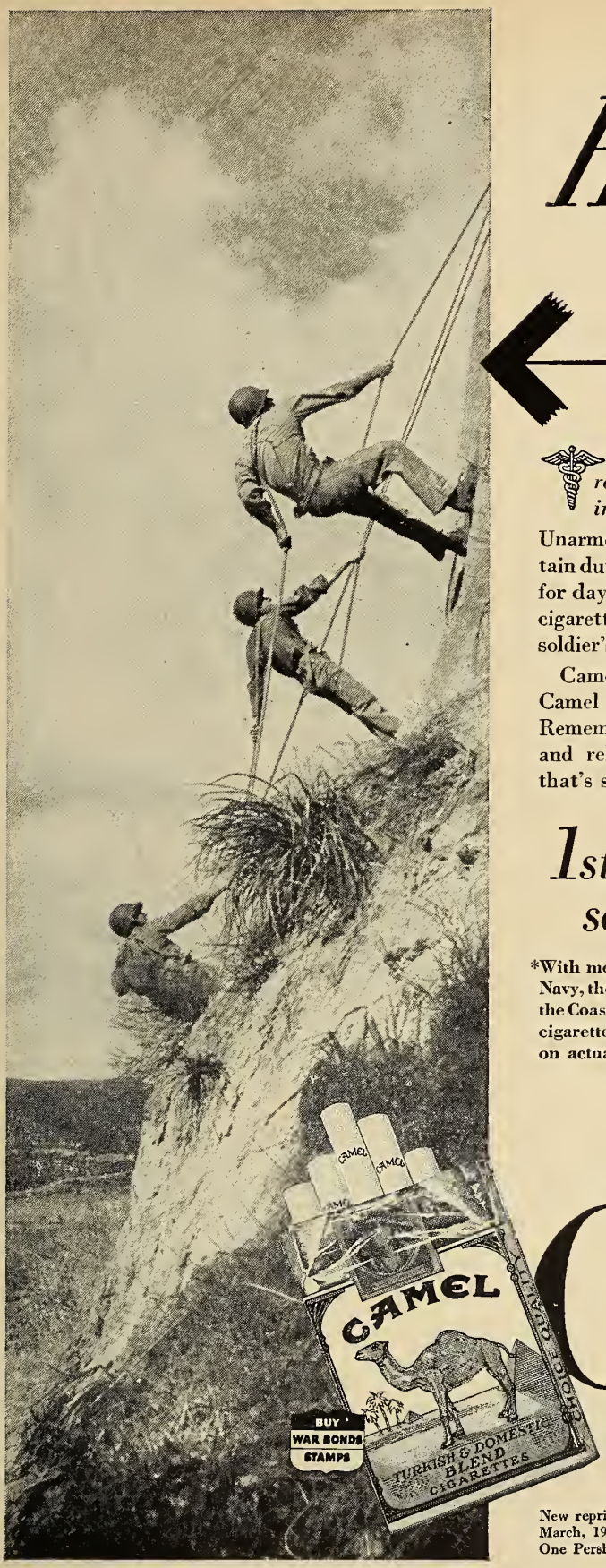
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Healers on the heights

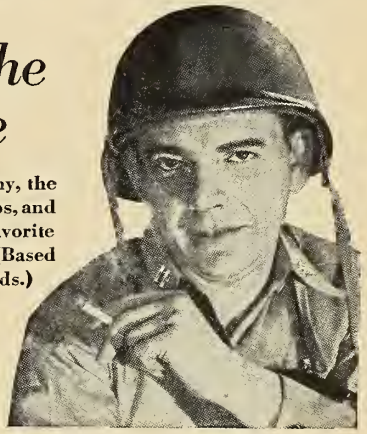
Crawling the crags at dawn . . . Exposed on rocky ledges in the blistering noonday sun . . . Fighting pain and death through the freezing night . . .

Unarmed and unafraid, the medical officer on mountain duty is often marooned amid harrowing hardships for days on end, unrelieved except for an occasional cigarette . . . a cheering Camel most likely . . . the soldier's favorite smoke.

Camel is first choice of the armed forces* because Camel rates first for mildness, first for fine flavor. Remember that—when you send cigarettes to friends and relatives in service. Send Camels—the brand that's sure to please.

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New reprint available on cigarette research — Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

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is the highly purified, non-irritating extract of Plantago ovata (50%) combined with anhydrous dextrose (50%). Metamucil mixes readily with liquids. Metamucil is palatable. Metamucil is easy to take.

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SEARLE
RESEARCH IN THE SERVICE OF MEDICINE

WAR BULLETINS

MEDICAL TREATMENT, U. S. ARMY PERSONNEL

1. All military personnel are entitled to necessary medical care at Government expense providing they are not absent from their organizations and stations *without permission.* Medical care in civilian institutions and/or by civilian physicians must be limited to emergency conditions.

2. Fees to physicians and hospitals cannot be allowed if Government facilities for the care and treatment are available within reasonable distance. Fees for elective medical care will not be authorized.

3. If treatment to military personnel is given by civilian agencies, *immediate* notification of the facts and circumstances should be made to the Commanding General, Sixth Service Command, 20 North Wacker Drive, Chicago 6, Illinois.

4. Private accommodation in civilian hospitals will not be authorized except upon approval of this headquarters.

5. Fees for tissue microscopy are not allowable.

6. Itemized statement of services rendered should be forwarded to this headquarters for vouchering and payment immediately on termination of the service.

For the Commanding General:

DON G. HILLDRUP,
Col., M.C., Surgeon.

Army Service Forces,
Headquarters Sixth Service Command,
Chicago 6, Illinois

February 11, 1944.

THE TIME IS NOW

An editorial in the November *Westchester* (New York) *Medical Bulletin* is timely:

Our failure clearly to interpret ourselves, our accomplishments, and our sincere purpose to the American people has rendered the art and science of American medicine exquisitely vulnerable to political manipulation by a bureaucracy seeking new ways of perpetuating its power. Furthermore, medicine's position of responsibility to the public places it at the mercy of political attack or envelopment.

What *can* be done, . . . what *must* be done, if we are to fulfill our fundamental obligation to the American people, and our responsibility to those who will follow us in our profession?

First, we can, even at this eleventh hour, *frankly and honestly tell our own story,* utilizing *in our own name* all the available means and media of modern public relations. If the American Medical Association must forfeit its tax-exempt status for the privilege of interpreting, not itself, but the medical profession to the American people (an assertion which we don't believe and hereby challenge)—then by all means let us buy our chips and get into the game! *Is it more important to the welfare of the American people for us to be exempt from taxes than from bureaucratic dictation?*

Second, we *can,* even at this eleventh hour, *establish an information and service bureau in Washington,* openly dedicated to the need of maintaining a continuous two-way channel of intercommunication between the medical profession and the people, the Federal agencies, and legislators who are interested in the services we render. The need for a Washington office for the American Medical Association is so obvious and urgent as to make any further delay in its establishment a matter of criminal negligence, in our opinion.

Third, we *can,* even at this eleventh hour, *assume our earned and rightful place of leadership* in the councils of those who seek to mould the future of our calling. We must certainly expect great and fundamental social changes; we will probably have to accept an increasing degree of proper governmental participation in medical service. But in any case, the profession must assert and maintain a definite status in the formulation of all legislation on health and medical matters. Merely to confer with governmental agencies cannot reasonably be construed as evidence that medicine has accepted their theories or philosophies concerning medical service. On the contrary, medicine owes it to the public, as it surely owes it to its own members, to assert its earned leadership in determining its own future.

The time is now!

MEDICAL STUDENTS

Eighteen women and sixteen men students of a total enrollment of 275 at Wayne University School of Medicine are civilians.

Under the new accelerated quarterly plan the seventy-seven men and women in the freshman class will be graduated in three years instead of four as formerly. Graduation of upperclassmen will be similarly hastened. The college operates continuously through the year, with four twelve-week instructional periods separated by one-week furloughs.

Of the total 275 enrolled, 178 will eventually see active service in the Army, and sixty-three in the Navy. It is likely that this accelerated training plan will be continued for at least five years after the war, to provide replacements and to fill the growing demand for doctors.

Returning Medical Corps Officers.—Of the 55,000 Doctors of Medicine in the armed forces, it is anticipated that approximately 15,000 will be kept in service for ten years after the present war is finished. Of the remaining, it is estimated that 60 per cent will return to the work they were doing before the war, and that 15 to 20 per cent, representing in the main the nine months' interns who never practiced medicine, will seek some postgraduate or preceptor experience.

BUY WAR BONDS

CHEMOTHERAPY MARCHES ON



PENICILLIN

Lederle

SEARCH FOR BACTERIOSTATIC AGENTS active in man, but not harmful to him, has proceeded for thousands of years. With the discovery of the sulfonamides the first breach was made in what seemed to be an impenetrable wall across the path of scientific advance. The immense scientific interest in this subject stimulated investigation of other bacteriostatic agents. Old data were re-examined in the light of new developments with at least one outstanding result—*Penicillin.*

In 1929 Fleming[1] was led to publish observations arising from a troublesome phenomenon occurring in plate cultures—contamination with molds. He found that a *Penicillium* mold produced a powerful anti-bacterial substance and suggested that this material might be used for the treatment of infections in man. Not until 1940 however did Chain, Florey[2] and their associates re-examine the prior work of Fleming, confirm his original observations and describe isolation of the active principle—*Penicillin.*

Lederle Laboratories had conducted laboratory research for many years on the growth of molds and the investigation of their products. Today, Lederle is working on a 24 hour schedule to produce Penicillin.



This entire building at our Pearl River laboratories is devoted exclusively to the manufacture of Penicillin

REFERENCES: [1]FLEMING, A.: Brit. J. Exper. Path. 10: 226 (June) 1929.
[2]CHAIN, E.; FLOREY, H. W.; GARDNER, A. D.; JENNINGS, M. A.; ORR-EWING, J., and SANDERS, A. G.: Lancet 2: 226 (Aug. 24) 1940.

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Editorial Comment

MENE, MENE, TEKEL, UPHARSIN

These were the words written upon the wall at Belshazzar's[1] feast. What is their significance for American medicine today? Translated freely, the words mean: the years of your sovereignty are numbered and finished; you have been weighed in the balance and found wanting; your kingdom is divided and given away. In the role of very modern Daniels, Messrs. Wagner, Murray, and Dingell have done a job of translating the handwriting into proposed federal legislation! Perhaps in the hope that a chain of gold will be put about their necks?[2] It is a delicate hope.

At the hour of this writing "the fingers of a man's hand" have come forth and are writing "over against the plaster of the wall" the fact of the seizure of the struck coal mines by the government. In Congress there lies embodied in *S. 1161* and its companion bill the mechanism for the virtual seizure of the medical profession by the government, compensated by the sum of $3,048,000,000 annually of the taxpayers' money, but containing no provision for the return of the profession to its present status of free enterprise after the war or at any other time.

Perhaps it can happen here. *It can happen if the people neglect to say they do not want it.* Or if they are indifferent to whatever happens. Something like it has happened in Germany, in England, in New Zealand. In the United States the medical and hospitalization provisions of *S. 1161* are tied in with many other aspects of social security of which organized medicine approves. But doctors cannot be expected to applaud nor will the public approve if rightly informed of a bald-faced attempt to sell the entire medical profession into slavery to the Surgeon General of the U.S.P.H.S. forever. If this bill becomes law, it will be possible to say of this official: "Whom he would he slew; and whom he would he kept alive; and whom he would he set up; and whom he would he put down."

Seizure by government of struck mines to maintain absolutely essential coal production in wartime is one thing. Attempted seizure of the medical profession and its affiliated institutions, in none of which is anyone on strike but, on the contrary, producing to capacity with 45,000 and more of its limited physician personnel in the armed services, is quite another. The significance of the handwriting on the wall is the *attempt* of the government to expropriate and socialize the medical profession of the United States, to sell it into virtual slavery to the Surgeon General of the U.S.P.H.S. when the large number of physicians who are serving the nation in the armed services are in no position to do anything about it. The fact that the A. F. of L. and the C. I. O. seem to be in favor of such seizure of the profession of medicine and have assisted in the writing of the medical and hospitalization provisions of the bill to accomplish it does not, in our opinion, particularly recommend it in the light of the records of the performance of these gentlemen with respect to the public interest. But politics makes strange bedfellows, and it may come to pass that Daniels Wagner, Murray, and Dingell may not, after all, have been such accurate interpreters, politically speaking, of what the fingers of a man's hand were indeed writing over against the plaster of the wall.—Editorial, *New York State Journal of Medicine,* January 15, 1944.

[1]Daniel 5:25 *et seq.*
[2]*Ibid.,* 529.

A BACKWARD STEP

The Wagner-Murray-Dingell Bill, if enacted in its present form, would impose upon this country a system of arbitrary political medicine centralized in Washington.

Among the powers it would confer on the Surgeon General of the United States Public Health Service are these:

1—To hire doctors and fix their salaries.
2—To designate which doctors can be specialists.
3—To determine the number of patients any physician may attend.
4—To decide what hospitals or clinics may provide service to patients.

The only restraint upon the Surgeon General in the exercise of these powers would be the "advice" of a council whose members he himself had appointed.

The dictatorial authority thus vested in one man over the medical profession and its patients goes far beyond anything Sir William Beveridge dared to propose in his recent social security report for Great Britain.

* * *

The United States is the healthiest country in the world. This is because its physicians and surgeons and research men and women have been intelligent, alert and progressive.

The first result of putting them under political domination would be to lower standards of efficiency and destroy initiative. Professional rating would be no higher than necessary to stay on the Surgeon General's approved list. Our personal relations with our doctors would be blighted with political interference—a curse on the Nation.

While there are areas in the country where poverty or ignorance or both have prevented the development of adequate hospital and medical facilities, their problem can be corrected by direct attack, without penalizing other areas, where the proposed system would mean lowering existing standards. We can see no purpose in providing better medical attention for people in the Ozarks at the expense of people in Michigan, who can get a superior quality of medical and hospital service today, at less cost, than the Wagner-Murray-Dingell scheme would provide them. The backward districts can be dealt with by the Government, if it wishes, through their State organizations.

* * *

This newspaper feels that there is much that is wrong with the medical profession, much that could be corrected by a wider visioned and more socially conscious leadership in the American Medical Association. But the Wagner-Murray-Dingell Bill is a fatal remedy for the curing of any such maladjustments.

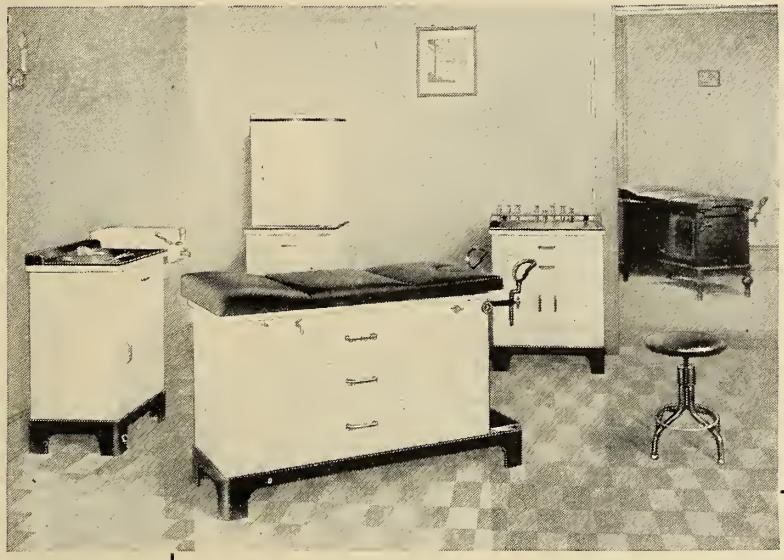
For example, some day a progressive AMA will demand that every practicing physician must submit to a State examination annually to make sure that he has kept abreast of the development of the science of medicine. Too many doctors have not looked at a book or made additional study since they first hung up their shingles.

But this new proposal makes a political football out of a profession with a relationship to the people that is almost as sacred as that of the clergy.

The faults of the profession are obvious. This bill kills the good with the bad.—Editorial, *Detroit Free Press.*

(Continued on Page 190)

STEELTONE . . . most
Modern Steel Medical Furniture made



Give your office distinctive beauty and style with this new Hamilton Steeltone Furniture. Now more than ever modern equipment is essential. Made of heavy steel for long life . . . streamlined in appearance . . . easy to clean. This furniture is worth seeing! See it at Randolph's.

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(Continued from Page 188)

AN OPPORTUNITY FOR DISTINGUISHED SERVICE

There is nothing to be gained by "crying over spilled milk," but the imminent threat of the control of medicine by the Federal government shows very clearly that an agency of the American Medical Association, with the functions of the new Council on Medical Service and Public Relations, should have been in operation for at least the past ten years. That, of course, is not the fault of the new Council. But the urgency of the issues now confronting Medicine points the need to rapid organization and approach to these problems by the Council. This critical condition, in our opinion, calls for strong leadership and national planning on the part of the Council.

Inasmuch as any sound plan or plans—national, state or local—designed to improve medical care must provide for preventive as well as curative treatment, and for hospital services, might it not be advisable to make the formulation of a national broad-gauge plan the joint responsibility of the American Medical Association (through the Council on Medical Service and Public Relations), the American Public Health Association, and the American Hospital Association? Besides the obvious reasons for this proposal there is an added motive for the suggestion: A plan formulated in this way by this group would be more apt to receive favorable public recognition than if proposed by the American Medical Association alone. Rightly or wrongly, the Association, at the moment, is regarded by the public in many quarters as a reactionary institution, insistent upon retaining the status quo and insensible to new ideas for improvement in the methods of furnishing medical care.

It is realized, of course, that a great part of the problem involved in providing better medical care is economic. It is not sufficient answer, however, to point out that the reason some groups, or residents of certain areas of the nation, are not receiving better medical care is the result of poor economic conditions, low level of income, lack of education, and a disinclination to avail themselves of good medical care. Regardless of these or any other factors *all* of the people of this country should have available the means of securing adequate medical care.

Apparently, at least for the time being, there is to be *no office* of the American Medical Association in Washington. We understand, however, that one and perhaps two representatives of the Association will be in Washington to maintain contacts with the various bureaus, and presumably to advise the Council on legislation of interest and import to the profession. While this perhaps is an improvement, we still hold strongly to the conviction that to do a *good* job in public relations, to be in a position to furnish the legislators, the public and the medical profession with needed information concerning legislation or regulations affecting public health and medical service, an adequate staff *with an office in Washington* is essential. If, perchance, an office of the Association is subsequently established in Washington, we suggest a prompt public announcement of the fact and a frank statement of its purposes.—Editorial, *The Journal of the Medical Society of the State of New Jersey,* December, 1943.

It is apparent from the trend of proposed legislation, as well as from a study of existing laws and regulations, that in the opinion of many persons even the present industrialization of medical practice does not go far enough. They would have it completely federalized. This tendency is in line with the undoubted trend toward the breakdown of local and state autonomy in favor of federal control. There is nothing novel about it, except that it has been relatively untried in this country. War, however, tends to hasten the ordinarily slow processes of evolution. Medicine itself, acting in an advisory capacity to the American people, can only present to them its wealth of experience with the philosophy and practice of the art and science which it has developed.

What the people will have to say concerning the federalization of the profession or of the nation's economy seems yet to be anybody's guess. What the people want they can have by the orderly processes of law and elections guaranteed by the Constitution.—Editorial, *New York State Journal of Medicine,* January 15, 1944.

No discussion of things medical is now complete without a few comments on Senate Bill 1161. By now, no self-respecting doctor, however busy, has missed the significance of its provisions or avoided wondering just what should be done about it. In a recent public meeting in Salt Lake City a well-known judge and a prominent engineer expressed themselves about as follows: "You medical men are too prone to resist change. Obviously a change is in the making for you and the Wagner-Murray Bill may be looked upon as the initial gesture. But your criticism is too unconstructive. You condemn without offering an alternate plan." To some extent this accusation was well justified. Most of us are doing quite well in a material way and naturally we should like things to remain in status quo. Our ego is comfortably expanded, but things in the medical world are obviously due for a change and the only conclusion that suggests itself is that we must cease thinking in terms of "I" and begin to think in terms of "We." In short, we must organize effectively.

A very convincing demonstration of the power of effective organization has lately been presented to the people of America by Mr. Lewis and his coal miners. God forbid that members of the American medical profession should ever consider walking out on their natural responsibilities in such a manner. Medical men could probably never be organized to the degree of thoughtless compliance evident in the labor unions. Nevertheless, the only effective answer to the present congressional threat is united action on a solid front. —Editorial, *Rocky Mountain Medical Journal,* February, 1944.

One may make the general observation . . . that if the rank and file of our Society does not undertake to think through the economic problems facing the medical profession this very hour, there may be nothing to debate at some future session except how to maintain standards of medical practice under complete regimentation and subsidization.—Editorial, *Pennsylvania Medical Journal,* December, 1943.

This maternal and infant care program is not a threat of government control of the practice of medicine.

It IS that control.—Editorial, *Rocky Mountain Medical Journal,* December, 1943.



An Announcement

After six years of extensive laboratory and clinical research, ESTINYL Tablets are now available for the treatment of various estrogen deficiency states.

ESTINYL is a derivative of the natural follicular hormone, alpha-estradiol. Chemically, it is *17 ethinyl estradiol*, and is the most potent oral estrogen known.

Being related to alpha-estradiol, it imparts a feeling of general well-being common to all natural estrogens; and administered in therapeutic doses, undesirable side reactions are uncommon.

Rapid and physiologic relief of menopausal symptoms may be obtained safely and economically by administering two or three 0.05 mg. ESTINYL Tablets daily for one or two weeks. Therapeutic effects may frequently be maintained thereafter with one tablet daily, or every other day.

Available as ESTINYL Tablets of 0.05 mg. and 0.02 mg.; bottles of 30, 60 and 250.

LITERATURE ON REQUEST

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COUNTY SECRETARIES CONFERENCE HAS LARGE ATTENDANCE

Over 200 attended the Annual County Secretaries' Conference and "School of Information," sponsored by the Michigan State Medical Society and held at the Book-Cadillac Hotel, Detroit, on January 30. Unanimous was the praise for an intensely interesting and enlightening program. The speakers who presented "Trends in the Regimentation of Medicine" were J. W. Holloway, Jr., Chicago, Director of the Bureau of Legal Medicine and Legislation, AMA; R. L. Novy, M.D., Detroit, President, Michigan Medical Service; L. Fernald Foster, M.D., Bay City, Secretary, Bay County and Michigan State Medical Societies; and Wm. J. Burns, Lansing, Executive Secretary, Michigan State Medical Society.

"The Need for Public Relations" was explained by Edward J. McCormick, M.D., Toledo, Member of Council on Medical Service and Public Relations, AMA.

"Bureaucracy as it Affects Medicine" was outlined by Floyd E. Armstrong, Cambridge, Massachusetts, Professor of Economics, M.I.T.

"Information to the Public—What to Present and How to Present It" was the dual subject of Thomas A. Hendricks, Indianapolis, Secretary of the Indiana State Medical Association, and Paul D. Bagwell, East Lansing, Head, Speech Department, Michigan State College. G. Lombard Kelly, M.D., Chicago, Secretary of the Council on Medical Service and Public Relations, AMA, discussed the papers of the day.

An Exhibit on "American Medicine and Medical Service" was presented by the Committee on Scientific Exhibit, AMA, with Thomas G. Hull, Director, in personal charge.

T. Y. Ho, M.D., St. Johns, Secretary for twenty years of the Clinton County Medical Society, was elected chairman for the ensuing year.

The forty-two County Secretaries present at the Conference were:

Florence Ames, M.D., Monroe; E. B. Andersen, M.D., Dickinson-Iron; James E. Bailey, M.D., Branch; Helen S. Barnard, M.D., Muskegon; H. M. Best, M.D., Lapeer; E. W. Blanchard, M.D., Sanilac; A. L. Callery, M.D., St. Clair; C. C. Corkill, M.D., St. Joseph; Frank Doran, M.D., Kent; Ray M. Duffy, M.D., Livingston; F. Mansel Dunn, M.D., Ingham; L. Fernald Foster, M.D., Bay-Arenac-Iosco; Sidey Franklin, M.D., Luce; C. L. Grant, M.D., Manistee; J. Bates Henderson, M.D., Huron; T. Y. Ho, M.D., Clinton; W. O. Jennings, M.D., Kalamazoo; W. S. Jones, M.D., Menominee; Felix J. Kemp, M.D., Oakland; Robert T. Lossman, M.D., Grand Traverse-Leelanau-Benzie; W. S. Mackenzie, M.D., Lenawee; John A. MacNeal, M.D., Hillsdale; James E. Mahan, M.D., Allegan; L. C. Manni, M.D., Calhoun; J. J. McCann, M.D., Ionia-Montcalm; A. H. Miller, M.D., Delta-Schoolcraft; E. S. Parmenter, M.D., Alpena; Charles Paukstis, M.D., Mason; Horace W. Porter, M.D., Jackson; C. A. Ruedisueli, M.D., Macomb; Ralph R. Sachs, M.D., Midland; Gilbert B. Saltonstall, M.D., Northern Michigan; L. G. Sevener, M.D., Eaton; John C. Shoemaker, M.D., Tuscola; Charles R. Smith, M.D., Houghton-Baraga-Keeweenaw; R. W. Spalding, M.D., Van Buren; Stanley A. Stealy, M.D.; North Central; Gordon C. Tornberg, M.D., Wexford-Missaukee; Richard L. Waggoner, M.D., Gratiot-Isabella-Clare; H. S. Wedel, M.D., Barry; W. Westrate, M.D., Ottawa; E. R. Witwer, M.D., Wayne.

Keymen representing County Medical Societies were:

J. M. Atkinson, M.D., St. Clair; Robert H. Baker, M.D., Oakland; Hugh M. Beebe, M.D., Washtenaw; E. F. Brunson, M.D., Allegan; C. G. Clippert, M.D., Northern Michigan; B. R. Corbus, M.D., Kent; Luther W. Day, M.D., Hillsdale; W. S. Gamble, M.D., Bay; W. J. Herrington, M.D., Huron; L. E. Holly, M.D., Muskegon; H. G. Huntington, M.D., Livingston; R. M. Kempton, M.D., Saginaw; Alfred LaBine, M.D., Houghton; C. A. E. Lund, M.D., Barry; Lyman M. McBryde, M.D., Chippewa-Mackinac; T. A. McDonald, M.D., Monroe; Esli T. Morden, M.D., Lenawee; Melvin H. Pike, M.D., Midland; W. Joe Smith, M.D., Wexford-Missaukee; Edmund S. Socha, M.D., Ionia-Montcalm; R. A. Springer, M.D., St. Joseph; W. Ellwood Tew, M.D., Gogebic; Don W. Thorup, M.D., Berrien; John W. Towey, M.D., Menominee; Carl G. Wencke, M.D., Calhoun; Harry L. Weitz, M.D., Grand Traverse; D. Bruce Wiley, M.D., Macomb; M. G. Wood, M.D., Oceana; H. B. Zemmer, M.D., Lapeer.

Presidents of County Medical Societies who attended were:

Wyman D. Barrett, M.D., Wayne; Theodore I. Bauer, M.D., Ingham; J. E. Church, M.D., Oakland; Willis L. Dixon, M.D., Kent; R. H. Freyberg, M.D., Washtenaw; Harold H. Gay, M.D., Midland; Fred Henderson, M.D., Berrien; Albert Heustis, M.D., Monroe; E. B. Johnson, M.D., Allegan; Mana Kessler, M.D., Bay; C. P. Lathrop, M.D., Barry; M. J. McLaughlin, M.D., Jackson; Michael R. Murphy, M.D., Wexford; D. J. O'Brien, M.D., Lapeer; Hazel R. Prentice, M.D., Kalamazoo; Raymond T. Saxen, M.D., Newaygo; C. A. Scheurer, M.D., Huron; Edgar C. Sites, M.D., St. Clair; M. M. Wilde, M.D., Macomb.

Representatives of the Woman's Auxiliary, totalling thirty-nine, were present:

Mrs. R. H. Alter, Jackson; Mrs. T. Grover Amos, Wayne; Mrs. Sherman E. Andrews, Kalamazoo; Mrs. R. M. Athay, Wayne; Mrs. W. E. Barstow, Gratiot-Isabella-Clare; Mrs. T. I. Bauer, Ingham; Mrs. Walter H. Boughner, St. Clair; Mrs. G. M. Brown, Bay; Mrs. A. S. Brunk, Wayne; Mrs. F. G. Buesser, Wayne; Mrs. A. L. Callery, St. Clair; Mrs. C. G. Clippert, North Central; Mrs. Milton A. Darling, Wayne; Mrs. Thomas Hackett, Jackson; Mrs. L. C. Harvie, Saginaw; Mrs. L. C. Himler, Washtenaw; Mrs. Otto S. Hult, Delta-Schoolcraft; Mrs. Wm. A. Hyland, Kent; Mrs. Wm. B. Kerr, Saginaw; Mrs. C. R. Keyport, North Central; Mrs. A. S. Kimball, Oakland; Mrs. W. Mackersie, Wayne; Mrs. G. L. McClellan, Wayne; Mrs. V. M. Moore, Kent; Mrs. Melvin H. Pike, Midland; Mrs. H. A. Ramesdell, Manistee; Mrs. Thos. A. Ramsdell, Manistee; Mrs. P. A. Riley, Jackson; Mrs. A. C. Roche, Houghton-Baraga-Keeweenaw; Mrs. Ralph R. Sachs, Midland; Mrs. W. L. Sherman, Wayne; Mrs. E. F. Sladek, G. Traverse-Leelanau-Benzie; Mrs. L. Paul Sonda, Wayne; Mrs. R. A. Springer, St. Joseph; Mrs. Oscar Stryker, Newaygo; Mrs. R. L. Waggoner, Gratiot-Isabella-Clare; Mrs. John J. Walch, Delta-Schoolcraft; Mrs. Roger V. Walker, Wayne; Mrs. G. L. Willoughby, Genesee.

MSMS Officers who attended included:

President C. R. Keyport, M.D., President-elect A. S. Brunk, M.D., Treasurer Wm. A. Hyland, M.D., Speaker P. L. Ledwidge, M.D., and Councilors W. E. Barstow, M.D., T. E. DeGurse, M.D., R. J. Hubbell, M.D., W. H. Huron, M.D., R. S. Morrish, M.D., R. C. Perkins, M.D., P. A. Riley, M.D., E. F. Sladek, M.D., O. D. Stryker, M.D., and C. E. Umphrey, M.D.

Editors present were:

Wilfrid Haughey, M.D., JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY; Wm. S. Reveno, M.D., *Detroit Medical News.*

Members of the MSMS Public Relations Committee who attended were:

Fred R. Reed, M.D., Chairman, J. S. DeTar, M.D., and Homer A. Ramsdell, M.D.

Others who attended included:

T. G. Amos, M.D., Detroit; R. M. Athay, M.D., Detroit; Joseph J. Bauser, Detroit; James A. Bechtel, Detroit; Henry C. Black, Battle Creek; D. C. Bloemendaal, M.D., Zeeland; W. H. Baughner, M.D., St. Clair; I. W. Brown, M.D., Kalamazoo; G. M. Brown, M.D., Bay City; Frederick G. Buesser, M.D., Detroit; Sara M. Burgess, Flint; John W. Castellucci, Detroit; C. H. Coghlan, Detroit; James E. Cole, M.D., Detroit; George Cooley, Toledo; F. M. Cordero, Detroit; Milton A. Darling, M.D., Detroit; Graham L. Davis, Battle Creek; Carleton Dean, M.D., Lansing; Fred Drummond, M.D., Kawkawlin; Wm. J. Griffin, LL.B., Detroit; H. W. Harrington, M.D., Sault Ste. Marie; Louis J. Hirschman, M.D., Detroit; H. S. Hosmer, Detroit; L. W. Hull, M.D., Detroit; A. F. Jennings, M.D., Detroit; O. F. Jens, M.D., Essexville; Jay C. Ketchum, Detroit; David Kliger, M.D., Detroit; Paul LaBine, Grand Rapids; Wm. M. LeFevre, M.D., Muskegon; James Lightbody, M.D., Detroit; Henry A. Luce, M.D., Detroit; John R. Mannix, Detroit; K. E. Markuson, M.D., East Lansing; G. L. McClellan, M.D., Detroit; John W. Nagle, M.D., Detroit; R. L. Novy, M.D., Detroit; J. M. Robb, M.D., Detroit; C. J. Sevener, M.D., Charlotte; Allen Shoenfield, Lansing; F. M. Shuster, Detroit; Lillian R. Smith, M.D., Lansing; P. R. Urmston, M.D., Bay City; W. R. Vaughan, M.D., Plainwell; Forsythe Warren, M.D., Ann Arbor; G. H. Wood, M.D., Detroit; Grace Wallace, Detroit.

Table of Contents

Preventable Blindness.
Peter C. Kronfeld, M.D. 209

Management of Large Vesical Calculi.
Ira G. Downer, M.D. 214

Clinical, Histopathological and Inheritance Factors in Peroneal Muscular Atrophy (Charcot-Marie-Tooth Type).
Lt. Comdr. Louis Adrian Schwartz, USNR 219

Rhinolith in a Child.
Frederick T. Munson, M.D. 231

Chordoma: Report of a Case.
William E. Keane, M.D. 232

President's Page:
No Need for Compulsory Federalized Medicine Here 235

Editorial:
Medical Evolution 234
Medical Education 234
Official Appointees 236
Have We a Program? 236

Michigan Doctors of Medicine in Military Service .. 237

Annual Session of the Council, MSMS 244

Annual Michigan Postgraduate Program for Graduates in Medicine 251

You and Your Business 252

Postgraduate Industrial Medical and Surgical Conference 254

Michigan's Department of Health 256

Woman's Auxiliary 258

County and Personal Activities 260

The Doctor's Library 264

War Bulletins 186

Editorial Comment 188

County Secretaries Conference 192

SUPPORTIVE SHOES PERMIT NORMAL EXERCISE OF FOOT

Hack Shoes provide balancing functional support that is moderate yet effective and permits normal use of the foot muscles and ligaments within the limits of elasticity. In view of the hard, unyielding surfaces upon which we walk, the support prevents strain beyond the limits of elasticity for the normal foot, improving the balance of the pathologic foot.

By balancing the foot in normal position, overcoming strain, flat feet are improved in exercise such as normal walking.

HACK SHOE COMPANY

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ut so far I have learned of no other e suggestion which provides the neces- fety valve which such an arrangement would give. It would be tragic if a lot ll business concerns were wrecked and orkers thrown into idleness because of nability to cut through the red tape ed in getting their claims settled.

RESPONSIBILITIES OF CONTRACTORS

le making these statements with re- o action by the Federal authorities, I ize, also, that business concerns which war contracts have a responsibility on part to facilitate speedy settlement of ated war contracts. They have the re- bility for preparing their claims ac- y and speedily and presenting them per form. Some progress has been toward getting a recognition of the at industry must play in this respect, rrently more and more experience of ort is now being gained. The con- ng services of the Government, I know, very helpful attitude toward this sit- , and the local office of W. P. B. has shed a regional advisory service for war faced with problems resulting from termination. That is a very helpful ment.

ation to make possible the prompt nt of terminated war contracts is now. It will be unsafe to wait until s a deluge of contract terminations to hrough legislation on short notice. roblem is too complicated to be dealt ffectively in that way.

ATERIALS FOR CIVILIAN PRODUCTION

ddition to making provision for the ent of terminated war contracts, there the task of facilitating the flow of als for civilian production as soon as materials can be spared from war pur- I hope that we shall not have unem- ent here in Massachusetts because d materials, which are physically in ex- e in the United States, are unavailable by manufacturers as a result of leg- or administrative restrictions. The legislation vesting the priority power President, which power of the Presi- delegated to the Chairman of the War on Board, is probably adequate to the flow of materials, but it may be ry for the Congress to make sure that inistration of the priority power by ar Production Board is directed effec- toward the speedy and smooth resump- f civilian production. The War Pro- n Board should be directed to elimi- ts limitation orders, its conservation and its allocation systems just as as the needs of the war program per-

use of their effects on plans for re- yment, I foresee that these problems tiling canceled contracts and securing pplies of raw materials for civilian pro- n will presently be matters of wide- concern here in Massachusetts.

summarize, my specific recommenda- re that legislation should be enacted r the following points:

EMENT OF TERMINATED WAR CONTRACTS

terminated contracts should be set- egotiation by the contracting agen- he Government, and the negotiated nt should be final in the absence or misrepresentation.

mpt partial payments amounting to large percentage of the claim should d to each contractor upon submittal fied statement of the claim, subject, , to a penalty for perjury.

al settlement committees should be red to authorize partial payments delay of over 30 days occurs on the the Government agency.

4. Contracting agencies should be required to give prompt clearance of claims on work in process. There should be clear-cut procedures for authorizing the removal of Government-owned inventories and machines, with storage at Government expense, in order that civilian production may be started.

5. The dilemma of the subcontractors must be resolved. At the present time the Government exercises the right of approving all payments in settlement of subcontracts but does not assume any responsibility to the subcontractor, with the result that the subcontractor in many cases cannot secure action by either the prime contractor or the contracting agency. I suggest that the local settlement committees proposed above should be empowered to approve settlement of subcontracts if a delay occurs in approval by the contracting agency.

B. DECONTROL OF MATERIALS

1. As soon as war conditions permit, the rules for the release of source raw materials should be revised, with a view to facilitating the rapid resumption of civilian production.

A Magnificent Job

EXTENSION OF REMARKS
OF
HON. LOUIS LUDLOW
OF INDIANA
IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 11, 1944

Mr. LUDLOW. Mr. Speaker, Indianapolis and Indiana are very proud of the great pharmaceutical house of Eli Lilly & Co., which has processed its millionth blood donation without a cent of profit. This record is in keeping with the fine, generous spirit which this firm always has manifested in the service of our country and which long ago brought to it the recognition of an Army-Navy E award. Commenting on the company's contribution to the blood campaign, which means so much in saving the lives of our precious boys, the Indianapolis News says editorially:

LILLY'S CONTRIBUTION

In the midst of charges that some concerns are making an unholy profit from war contracts it is heartening to learn that the Indianapolis laboratories of Eli Lilly & Co. have processed 1,000,000 blood donations entirely on a nonprofit basis.

In addition to performing this service at cost, the expense involved has been decreased constantly through the introduction of more efficient methods.

There certainly could have been nothing unethical if the Indianapolis pharmaceutical house had sought a minimum profit for the work it has been doing.

Donations of blood at Atlanta, Chicago, St. Louis, Detroit, Cincinnati, Louisville, Columbus and Indianapolis have been converted into live-saving plasma at the Lilly plant, involving the installation of new equipment and the employment of much additional skilled personnel.

The patriotic Americans who donated this blood, however, got nothing for their contributions and the Lilly Co. determined that its connection wiht the effort to strengthen the wounded on every fighting front should be entirely shorn of private gain. From beginning to end, it has been and is—a magnificent job.

The Gates Must Not Be Closed

EXTENSION OF REMARKS
OF
HON. SAMUEL DICKSTEIN
OF NEW YORK
IN THE HOUSE OF REPRESENTAT

Tuesday, January 11, 1944

Mr. DICKSTEIN. Mr. Speaker, leave to extend my remarks in the ORD, I include the following editorial the Daily Mirror of January 4, 194

THE GATES MUST NOT BE CLOSE

When Congress reconvenes on Janu it should take up the Gillette-Taft-Bal Rogers resolution.

This resolution calls for the format a Presidential commission to create m ery, in conjunction with the Unite tions, to rescue the millions of Jew are now being systematically exterm by the Nazis and their Quislings.

When the Presidential commission g work, one of the first things it should to seek the abrogation of the Cham "White Paper" of May 1939.

At present, Palestine is being admin by Great Britain in conformity with t icy embodied in the "White Paper," tue of which Jewish immigration int tine is now limited and is to be pr stopped after March 31, 1944. The to be reduced to a permanent min 33 percent in the country and the land to Jews is to be practically pro

A DIRECT REPUDIATION

"This is a direct repudiation on En part of the League of Nations Manda the Balfour Declaration incorporated mandate of 1917.

According to this declaration, Palest to become a national Jewish home un protectorate of England.

In 1939, after the Jews had created ern civilization in what was practic Arabian desert, England turned he on her solemn promise of 1917.

This perfidity of Britain toward t was denounced by no one more vig than by Winston Churchill in Parlian the debate on the "White Paper" when he said:

MR. CHURCHILL'S REGRET

"As one intimately and responsib cerned in the earlier stages of our P policy, I could not stand by and see engagements into which Britain has before the world set aside for reason ministrative convenience or for the quiet life. I should feel personally rassed in the most acute manner myself by silence or inaction to what regard as an act of repudiation.

"I regret very much that the pledg Balfour Declaration, endorsed as it h by successive governments, and the tions under which we obtained the m have been violated by the Gover proposal.

"I select one point upon which plainly a breach and repudiation of four Declaration—the provision tha immigration can be stopped in 5 ye by the decision of an Arab majority. a plain breach of a solemn obligation

As the Palestine Mandate was ord the League of Nations, it cannot b gated even by Great Britain herself the consent of the League.

A SOLEMN OBLIGATION

But the Lesgue did not give its cons the 1939 abrogation.

Say you saw it in the Journal of the Michigan State Medical Society

The JOURNAL
of the Michigan State Medical Society
Issued Monthly Under the Direction of the Council
Volume 43 March, 1944 Number 3

Preventable Blindness

By Peter C. Kronfeld, M.D.
Chicago, Illinois



Director of Education, the Illinois Eye and Ear Infirmary; Associate Professor of Ophthalmology, the University of Illinois.

In all his efforts the ophthalmologist is handicapped by the great delicacy and vulnerability and the very limited recuperativeness of the human eye. Since it is beyond human power to alter these characteristic qualities of the organ of sight, the ophthalmologist's hopes lie in the field of prevention of blindness rather than in that of restoration of sight. The main group of ocular diseases in which a striking improvement in the visual end-results and thereby a striking reduction in the incidence of blindness can be brought about in the United States by earlier recognition and intensification of treatment and follow-up are the glaucomas, the ocular diseases characterized by progressive loss of vision attributable to an abnormally high intraocular pressure. The advent of special glaucoma clinics for the indigent portion of urban populations marks a big advance in the campaign against glaucoma. All practicing physicians are requested to contribute toward the success of this campaign by suspecting the presence of glaucoma in every patient with progressive loss of vision until appropriate tests have proved the contrary.

■ I deeply appreciate the honor of being permitted to represent the specialty of ophthalmology at this meeting. Deep in my heart, however, I have the feeling that suffering mankind would gain more if you and I changed places and if ophthalmology as a whole became the listener at meetings such as this one. In the course of the natural coöperation between general physician and ophthalmologist a great deal of valuable information concerning the nature of the disease in question changes hands. In my experience it has occurred much more often that the general physician has opened the eyes of the ophthalmologist than vice versa.

But here I am, with orders from my ophthalmological colleagues to put our best foot forward and, at the same time, make the utmost of this opportunity. Our fight against preventable blindness has seemed an appropriate subject and a subject well in line with the keynote of this meeting, the building up of a better and sounder postwar world.

Only a small portion of the ophthalmologist's daily work comes under the heading of prevention of blindness. Taking stock of his functions, he finds that these largely consist of:

1. Increasing visual efficiency and lessening ocular discomfort by prescribing glasses and correcting muscular disorders;
2. Mitigating the course of inflammatory, traumatic and neoplastic diseases by therapeutic measures which are directed at the etiological principle or are just palliative in nature;
3. Being a sympathetic bystander and a more or less accurate recorder of diseases, generally labelled as degenerative;
4. Restoring sight by surgical means—namely by removing the cataractous lens, by inducing a detached retina to return to its normal position, by grafting clear cornea into the place of opaque, diseased cornea or by performing an optical iridectomy.

In all his efforts the ophthalmologist is handicapped by the great delicacy and vulnerability and the very limited recuperativeness of the human eye. This applies especially to the layer of photo-

Read before the Third Annual Postgraduate Conference on War Medicine, the Seventy-eighth Annual Session of the Michigan State Medical Society, September 24, 1943, at Detroit.

receptors in the human eye, the retina. Quoting from the standard textbook of ophthalmology by Sir Stewart Duke-Elder:

"As the key tissue of the eye the retina carries the primary responsibility of the visual function, and the destruction of its tissues by any pathological process involves irreparable blindness. Moreover, its destruction is easy, partly because of the delicacy and complexity of its structure which rapidly falls a victim to noxious influences, and partly because of the intensity of its metabolism which is unable to support the deprivation of essential supplies with impunity for any length of time.

". . . In all their pathological changes, indeed, the neural elements of the retina degenerate, and never regenerate; and if they make abortive attempts at proliferation, these are only pathological curiosities without essential significance in a reparative process."

Since it is beyond human power to alter the characteristic delicacy and susceptiveness of the organ of sight, the ophthalmologist's hopes lie in the field of prevention of blindness rather than in that of restoration of sight. Thus the question arises what constitutes preventable blindness, or more specifically, what forms of blindness can you and I prevent in our own spheres of influence and by practicable measures?

Causes of Blindness

About the causes of blindness in the U.S.A. we are informed by several statistical studies[4,7] based on the ophthalmologist's diagnoses in applicants for, or recipients of, relief for the blind. From such reports the incidence of blindness is calculated to be that of from 75 to 125 blind people per 100,000 capita. Since such reports do not include cases of blindness in the economically-better-situated classes, the actual incidence of blindness is probably greater than 1:1000. On the other hand, any of the statistics based on applications for blind relief comprise a goodly number of individuals in whom sight could be restored by measures so simple as a cataract extraction.

For the State of Illinois H. S. Gradle[5] has estimated this number to be as high as 25 per cent. But we are here concerned not with the incidence of blindness, but rather with those forms of incurable blindness which definitely are preventable or may become so with further progress of medical knowledge and in a better postwar world. For the purpose of this discussion the statistics on the causes of blindness may be simplified by omitting all obviously curable and all rare forms of blindness. The result of such a simplification is shown in Table I:

TABLE I

Cause of Blindness	Relative Incidence (Within this series)
Congenital anomalies and hereditary diseases	10.4%
Trauma	15.4%
Ectogenous, ulcerative keratitis	6.0%
Trachoma	0.7%
Interstitial keratitis	1.5%
Optic atrophy	15.0%
Retinopathy due to vascular disease	11.0%
Uveitis	24.0%
Glaucomas	16.0%

Table I obviously represents the situation of some years ago. In many respects we are already living in a better world than is indicated in the table. A number of the diseases which were responsible for cases of blindness listed in the table, belong to a group with which the French ophthalmologist Villard[6] deals in an article entitled: "L'agonie et la mort de quelques maladies des yeux," eye diseases which are slowly being eradicated by preventive measures. Such diseases are gonoblenorrhea of the newborn as well as of the adult, luetic uveitis, tabetic optic atrophy, phlyctenular and interstitial keratitis and a few others. Still, for the purpose of this discussion it may be permissible to paint the situation blacker than it actually is, by taking as a basis the causes of blindness of ten or twenty years ago.

Congenital anomalies and the hereditary atrophic-degenerative diseases of the eye have been put into one group, chiefly because most of the former have also been proved to be truly hereditary conditions and not just accidental mishaps in the development of the eye. The ophthalmologist is apt to get an exaggerated idea of the incidence of such congenital defects because most parents find it very difficult to comprehend and to become reconciled to the fact that their "otherwise perfectly normal child" should be irreparably blind or visually handicapped for life. The

advice of several ophthalmologists is sought which fact serves to make the tragic fate of the visually-defective child more generally known. Thus we all are kept on our toes in the new field of eugenics in ophthalmology, a field which was given due consideration in our texts and handbooks before it became a fundamental principle in the ideology of National-socialism. In ophthalmology, unfortunately, we are somewhat handicapped by the fact that all three possible modes of hereditary transmission may occur in the same clinical entity. Retinitis pigmentosa, for instance, the typical hereditary, progressive, atrophic-degenerative disease of the photo-receptors in the retina, has been known to occur in a dominant, recessive, or sex-linked form. Thus it behooves the ophthalmologist to determine the mode of hereditary transmission for each individual case or family which in the vast and wide-open U.S.A. is a far more difficult task than in Switzerland, from which country a great many exact studies of the hereditary background of ocular disease have come. Despite all difficulties we are trying to put the principles of eugenics into practice. In fifty or a hundred years from now I am confident there will be fewer albinos, fewer cases of retinitis pigmentosa and of all the other heredo-degenerations of the retina.

Trauma

With regard to trauma as a cause of blindness, about ten years ago ophthalmologists went through a phase of great self-satisfaction when the reports of some of our largest industries showed drops in the annual number of serious industrial eye injuries per 10,000 employes from 7.7 in 1926 to 1.9 in 1933. But the report by the Committee on industrial ophthalmology of the section on ophthalmology of the American Medical Association which was read before the Fourth Annual Congress on Industrial Health in 1942[2] tells us very clearly that our fight against industrial eye injuries must go on. In this report the Committee points out:

"Although during the past twenty-five years much progress has been made in the field of protecting employe's eyes from industrial eye hazards, nevertheless the average number of eye injuries has not been materially reduced. This may be explained by an increasing number of machine operators and machines. Three hundred thousand compensable eye accidents yearly are still taking place. These do not include trivial accidents such as uncomplicated injuries due to superficial foreign bodies in the cornea or conjunctiva. Ninety per cent of the serious accidents are preventable. There are in the United States 8,000 industrially blind, and 80,000 employes blind in one eye due to industrial accidents. The progress of the prevention of eye accidents is not working satisfactorily, and continued efforts must be directed constantly to programs of accident prevention."

Needless to say, there have occurred and will continue to occur innumerable eye injuries which are preventable by reasonable measures. It would not be reasonable to ask that we wear safety glass goggles all the time, but many serious eye injuries could be prevented if the amateur mechanic, carpenter or plumber kept a pair of goggles at his home, in his garage or in his car and remembered to put them on whenever he does a "job" in which there is a possibility of splinters striking the eye. Our children, I believe, should be made more conscious of the dangers to the eye entailed in so many of their seemingly harmless games. I have heard it said that it is a valuable lesson for a child to go through the experience of a broken arm or leg. That may be so, but that principle is certainly not applicable to the eye. The ophthalmologists of the State of Illinois heaved more than one sigh of relief when the legislature passed the bill prohibiting the retail sale of fireworks.

Chemotherapy

From your eyes I read the question: "Hasn't chemotherapy modified the outcome of eye injuries?" In nonperforating injuries of the cornea, local plus internal administration of one of the sulfonamides has doubtlessly been more effective in preventing or checking infection than the various bactericides and disinfectants used previously. The reason is obvious: In the case of the sulfonamides, effective concentrations of the bacteriostatic substance can be maintained in the cornea for the entire duration of the corneal disease. The mercurial and other disinfectants can only be applied externally and penetrate very little into the tissue, since they enter into chemical reactions with the tissue proteins. By making the more radical measures of drastic thermocauterization or delimiting keratotomy unnecessary, chemotherapy with sulfonamides has reduced the amount of permanent scarring of the

cornea that invariably results from corneal infections following trauma. In some very severe and far-advanced cases chemotherapy has at least prevented the infectious process from spreading into the eye and thereby at least saved the eyeball. Most important in the general practice of medicine is the fact that local chemotherapy in the form of sulfathiazole ointments, is very effective in preventing corneal infection after the removal of a corneal or intracorneal foreign body. To me a very remarkable fact is that even the infection of the cornea with pseudomonas pyocyanea responds to early chemotherapy as has been shown by Dr. C. W. Lepard of this city and, experimentally, by Dr. H. H. Joy of Syracuse.

In perforating injuries of the eye the results obtained with sulfonamide therapy have been noticeably, though not strikingly, better than in the pre-sulfonamide era. This may be explained by the fact that so far most ophthalmologists have instituted sulfonamide therapy in cases of perforating injuries only in the presence of definite symptoms of suppurative infection. While chemotherapy in some if not many of these cases may have been successful in checking the infection and preventing its spread, the absorption and organization of the suppurative exudates in the posterior segment of the eye entailed far-reaching and irreversible anatomical alterations, making the eye blind by pulling the retina away from its moorings. Thus, in order to be really successful in penetrating injuries, sulfonamide therapy must be instituted before large masses of cellular exudates are poured into the vitreous chamber, that is in a stage of the infection in which it can not always be recognized with certainty. Bellows, in his article on Chemotherapy[3] says, "In endophthalmitis and panophthalmitis . . . the sulfonamide compounds must be used early to be effective." He continues: "However, even in ordinary clinical cases, in which the time of initial treatment frequently cannot be chosen, the results are not entirely discouraging." In a few cases of infection following cataract extraction performed by members of the staff of the Illinois Eye and Ear Infirmary, chemotherapy has definitely mitigated the course and outcome of the disease which in the pre-sulfonamide era would doubtlessly have resulted in complete destruction of the eyeball. Ophthalmologists will have to acquire the courage to institute sulfonamide therapy in all early cases of penetrating injury in which there is any likelihood of an intra-ocular infection, barring only patients in a state of poor general health. Employed in this fashion, that is prophylactically and on a mere suspicion, sulfonamides may be expected to reduce appreciably the rate of blindness resulting from penetrating injuries.

What has been said here with regard to the beneficial effects of sulfonamide therapy in corneal injuries applies also to ectogenous ulcerative keratitis and to trachoma. In both conditions the severity of the corneal inflammatory process and, consequently, the extent of corneal scarring has been reduced by the judicious use of sulfonamides.

Lues

Preventive medicine "shines" in the luetic diseases of the eye. The proper measures to prevent interstitial keratitis and neurosyphilis need not be discussed here in detail. Only prenatal antiluetic therapy before the 5th month affords definite protection against interstitial keratitis. And only very energetic treatment with arsenicals of early syphilis reduces the danger of neurosyphilis and of optic atrophy. Antiluetic therapy during the course of the interstitial keratitis or of the optic atrophy is of very questionable value as far as the ocular condition is concerned. These two conditions are again examples of ocular diseases of which the prevention is a very promising project, whereas their treatment once the disease has gained foothold in the eye has been very discouraging.

Vascular Disease

Retinal vascular disease is responsible for an appallingly large portion of incurable blindness. The vascular disease in the large majority of these cases is arteriosclerosis and arteriolosclerosis. I do not consider myself competent to discuss the question of the prevention of systemic vascular disease, but I would like to say here that the high incidence of vascular retinal disease is most disheartening and exasperating to the ophthalmologist.

Uveitis

In Table I, uveitis accounts for 24.0 per cent of incurable blindness, a percentage which has been reduced somewhat during the last ten years thanks to more effective antiluetic therapy. Still uveitis remains one of the great problems in ophthalmology to which, as far as I can see, you have a

very close analogue in internal medicine, viz., the arthritis problem. Most of the statements made in the primer on arthritis which appeared in the *Journal of the American Medical Association*[1] apply to uveitis without modification. The primer says that "arthritis occurs in a number of different forms depending on various etiologic agents. Some of the groups are characterized by certain pathologic and clinical features which make their differentiation comparatively easy. In other instances only the most careful study will determine the identity of the articular disorder . . . In the majority of cases the etiology of the particular disease cannot be definitely determined . . . This is the group of probably infectious arthritis, but of unproved etiology." Exactly the same situation prevails in ophthalmology with regard to many forms of chronic or recurrent uveitis. Our theories concerning the pathogensis of these uveitides are strikingly the same as those concerning the pathogenesis of chronic rheumatoid arthritis. Despite all possible therapeutic efforts, in a goodly percentage of chronic uveitis blindness ensues. I fail to see any clues suggesting new lines of approach to the problem of the etiology and treatment of these uveitides and therefore do not expect any radical improvement of the situation in the near future.

The Glaucomas

This brings us to the last item on our list: the glaucomas. I definitely prefer the term, "The Glaucomas" because it expresses the heterogeneity of this large group of diseases which have in common only the one characteristic of progressive loss of visual function attributable to a state of abnormally high intra-ocular pressure. The three most important facts about the glaucomas are:

1. In a large number of cases glaucoma is not associated with ocular pain or discomfort in any form nor with any positive visual symptoms such as the seeing of haloes or rainbows around lights. This asymptomatic form of glaucoma is probably the most dangerous one because most patients do not become aware of it until a great deal of visual function, very often one whole eye, is lost.

2. Visual losses due to glaucoma, with the exception of those due to cloudiness of the cornea, are incurable and irreparable. Treatment, medicinal or surgical, can only prevent further loss.

3. In most cases loss of visual function due to glaucoma is or would have been preventable by relatively simple means. Many glaucomas respond favorably to conservative therapy.

4. Ineffectiveness of the therapeutic measures taken by the ophthalmologist accounts only for a small percentage of the blindness due to glaucoma that occurs in the U.S.A. Most of this blindness occurs because the disease was not recognized.

Thus the problem of reducing the amount of blindness due to glaucoma is largely a problem of early diagnosis. Since the disease may be asymptomatic except for a slow deterioration of vision and the elevation of pressure detectable only by specific tests, the fact that the patient has no complaints concerning his eyes and believes that his vision is normal is not sufficient evidence for the absence of glaucoma. While only the normal cooperation of two normal eyes provides the highest ocular function, namely stereopsis which enables naval, aerial and anti-aircraft gunners to use the modern rangefinders, in ordinary life unfortunately the vision of one eye may be lost entirely without the patient becoming in any way aware of this loss. Thus it is up to us to think of the possibility of glaucoma just as we think of or test for the presence of diabetes or hypertensive cardiovascular disease in any individual over forty. To me it would not seem too difficult or too laborious to include in every complete physical examination a test or two that would exclude the presence of advanced glaucoma. A peek at the patient's eye ground with the ophthalmoscope, a rough determination of the visual acuity with the patient's glasses and a rough field test by the confrontation method would seem adequate and at the same time not too time-consuming or difficult. In the not too distant future I hope that, to these simple tests, an examination of the intra-ocular pressure with the tonometer could be added. Such a program would not only be very much in the interest of the patient and his dependents but would also be of great value to the patient's employer, to the insurance company and the physician who share the responsibility for the patient's well-being.

But I believe we should go still further and try to detect glaucoma among the millions of citizens of this country who do not routinely and periodically pass through the office of a physician. Our children are given the benefit of routine

periodical eye examinations in school whereby gross ocular anomalies are detected. How could the adult population be given similar benefits? It seems to me that simple devices, not requiring an attendant, could be designed by which every adult could determine by himself whether the visual acuity of each eye and the visual field of each eye is within normal limits. I am thinking here of something like a "Penny Arcade," put up and maintained without cost to the "customer" by the Society of Prevention of Blindness of Shangri-la. Such devices could be placed in public buildings, at railway stations, and county fairs. An inscription on the device might simply say, "If you don't pass these tests, see your doctor right away." Such devices could be made attractive and interesting and would probably be more effective than posters or placards.

If a middle-aged or elderly person has discovered by himself or by the help of such devices that his vision is failing, it behooves all of us to suspect glaucoma until this suspicion is disproved by adequate tests. Unfortunately we (and I am including the ophthalmologists here) are very apt to be satisfied with a diagnosis of incipient cataract or with establishing the fact that the patient's visual acuity is improved by a change of glasses. The patient who is told that he has a beginning cataract or who is given a new pair of glasses has the right to think that that was the "whole trouble" and that nothing further can be done or has to be done, and that further loss of vision is still due to the cataract or calls again for a change of glasses. Thus both doctor and patient are lulled into a sense of false security.

Unfortunately, it happens only too often that a glaucoma is concealed behind an incipient cataract or that a glaucoma is the real cause of the patient's dissatisfaction with his glasses. In brief: A disease as insidious and inconspicuous as some of the glaucomas must be combated by suspecting it everywhere. Since you come in contact with a much broader section of the population, we have to ask you to carry most of the burden of suspecting and detecting glaucoma. Once it has been detected we shall do our very best to prevent any further loss, which usually means life-long observation and care. To carry out such treatment among the indigent special glaucoma clinics such as now exist in several large cities of the U.S.A. have proved very effective.

Ladies and Gentlemen, you have been what Deems Taylor would call well-tempered listeners to a subject that may seem of little importance compared to the gigantic medical issues of these days. Still, without you as an ally the benefits of preventive ophthalmology can never be made available to more than just a small portion of the nation.

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MSMS

Management of Large Vesical Calculi

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■ In the seventeenth century when cystolithiasis was a common disease and calculi attained enormous size, Frére Jacques,[20] originator of the lateral lithotomy, was reputed to say when he had completed the operation, "I have extracted the stone; I leave God to cure the patient." The mortality from sepsis following these early operations was high and rectal injury frequent. Today, despite several centuries of experience, lithotomy is still too often attended by severe postoperative infection, tremendous morbidity and high mortality.

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Removal of a urinary calculus is one of the oldest operations known to medicine and constituted one of the earliest specialties. It is mentioned in the writings of Hippocrates who described surgical procedures for the removal of stones but left the work of cutting for the stone to "practitioners of this art."[4] The first well recognized operation for bladder stone, according to Twinem,[20] was a median perineal lithotomy popularized by Ammonius of Alexandria in the third century B. C. Who first performed the operation is not known. This operation required only a knife and a hook. Later more instruments and modifications of this procedure came into use, including a lateral lithotomy in which the incision was made just medial to the left ischium. The so-called "grand appareil" (lithotomy with a staff) was first executed by Moranus Sanctus, who described the operation and the instruments necessary to perform it early in the sixteenth century. Needless to say, with these procedures, mortality was high.

Origin of the suprapubic lithotomy has been ascribed by different writers to the fourth[14] and to the sixteenth century[20] when it was employed by Franco, but the operation was used very little until the latter part of the last century, when the importance of obstruction in the etiology and development of urinary bladder calculi was appreciated. The development of surgical procedures for the removal of calculi was retarded by the popularity of lithotryptics (the oral administration of substances thought to possess lytic properties) with both the physician and the patient. It was not until 1818 that an instrument was employed to crush vesical calculi transurethrally. This instrument was the "trilabe" designed by Civiale.[14] It was improved in many ways in the years that followed, but the instruments in use today are chiefly the product of Bigelow.[3] In 1923 Goldstein and Lutz[8] advocated lithotrity under direct observation through the telescopic system of the cystoscope, and instruments developed for the purpose by Ravitch, Kirwin and Young are widely used.

Modern treatment of cystolithiasis has two principal forms, litholapaxy and suprapubic lithotomy, and in choosing the operation best suited, it is necessary to consider the following factors: (1) The condition of the patient, (2) the size and type of stone present, (3) the size of the urethra, prostate and bladder, and (4) in certain cases the removal of the lesion which predisposed to the calculus.

Recent years have shed little light on the cause of cystolithiasis despite much study. Two principal factors, working either singly or in concert, are probably responsible in most instances. The first of these factors is thought to be a disordered metabolism, producing primary stones, including uric acid, urates, and calcium oxalate deposited in acid urine, as well as crystalline calcium carbonate and phosphate precipitated from fairly alkaline or neutral urine. Primary stones have been held to be aseptic, but this is not altogether consistent with clinical findings, although it is possible they may be sterile when their formation begins.[14] Urinary colloids probably originating in the blood stream but possibly formed by the renal cells themselves, their amount varying greatly with the amount of protein in the diet, exert a protective action.[10] When the protective power of the colloids is abolished or appreciably diminished, a precipitate forms in the urine. It does not necessarily follow that a calculus will form, but a precipitate associated with stasis certainly predisposes. Keyser[11] produced artificial lithiasis by feeding oxamide and subsequently produced calcium oxalate stones in rabbits by feeding large amounts of calcium oxalate and causing concentration of the urine by dehydration. Calcium phosphate stones have similarly been produced by excessive doses of parathormone and viosterol.[14] In hypercalcemia due to hyperparathyroidism the calcium concentration of the urine is increased and the formation of urinary calculi is a prominent part of the disease.[2,6] Diets deficient in Vitamin A produce calculi of calcium phosphate in rats and dogs as shown by Osborne, Mendel and Ferry,[15] Fujimaki[7] and Van Leersum.[21]

The second factor is infection and the presence of foreign body; that is, something inserted through the urethra and remaining in the bladder, a nidus formed in the kidney and passing down the ureter, a clump of bacteria, pus cells, or epithelium. Randall[17] believes vesical calculi have their beginning in the papillae of the kidney and pass down the ureter to come to rest and grow in the bladder. Naegeli[14] believes that the calculi often form in the diverticula of the bladder. In the opinion of Bowers[4] there is something highly individualistic in some persons which predisposes to the formation of calculi.

Regardless of origin of the nidus, the influence

of stasis due to obstruction is of utmost importance in the growth of vesical calculi.

The incidence of cystolithiasis has changed radically in the last century.[14] In the Far East and in Europe 100 years ago it had a predilection for children. Today in Europe and in America it is primarily a disease of later life, occurring usually between the ages of forty and seventy. It is fifty times more common in the male than in the female, due doubtless to the fact that obstruction of the vesical neck (certainly prostatic hypertrophy), urethral stricture and vesical diverticula are primarily diseases of the male. Here in America, at the present time, renal calculi are more common than vesical calculi.

It is not infrequent for calculi, even very large ones, to exist for years without producing symptoms. The most consistent symptom is frequency of micturition, often so extreme that the patient must void every few minutes. Such a severe degree of tenesmus may be present that the bladder is in an almost constant state of spasm. Hematuria and pyuria are common findings and the termination of micturition is usually accompanied by hematuria and strangury as the stone comes to rest on the bladder base, stimulating the latter to contract and grasp the stone. Often the patient will describe sudden termination of the flow of urine and the ability to continue micturating on assuming a different position which will roll the stone from the internal meatus which it has occluded. Pain is usually present and is often relieved when the bladder becomes filled or when the patient is recumbent, that is, at such times as the stone leaves its lacerated bed and is cushioned by urine or comes to rest on less irritated mucosa. Any sudden jolt which thrusts the stone against the inflamed, irritated base of the bladder is a cause of severe distress.

The years have added much to diagnostic methods since the recognition of blood and pus in the urine by the early surgeons, until today Sherrill and Hall[18] state that "there is no department of surgery in which the refinements and the accuracy in the results of studies by methods of precision are so near perfection." The many refinements in radiographic studies, excretion radiography, cystoscopy, chemical, bacterial and microscopic studies of the urine, and blood chemistry estimation are invaluable aids in the diagnoses and management of these cases.

In the management of vesical calculi we have come far since the time of the itinerant lithotomists (itinerant, often refugee, by necessity). Very large calculi have usually been considered fatal. I do not believe this must necessarily be true. Cases where the calculi are too large or too hard to be crushed by the lithotrite, the urethra is too small in calibre to admit the instrument, and where the bladder is too small to admit sufficient water for utilization of transurethral procedures must of necessity be managed by cystotomy. The suprapubic approach has been most successful in my hands when attended by careful management.

The procedure should be divided into several stages. After careful estimation of the patient's condition, including blood chemistry studies, the first stage should be bilateral vasotomy with introduction of an indwelling urethral catheter if at all possible. This aids in preventing an ascending vasitis, epididymitis, or orchitis, if not already present, relieves the urinary obstruction and permits the clearing of bladder infection and the readjustment of fluid balance and kidney efficiency as much as possible under the circumstances. Further, it often adds much to the patient's comfort. Sulfonamides have been of inestimable value in reducing and controlling infection, while more recently one-sixth molar sodium lactate given intravenously has aided remarkably in readjusting fluid balance and raising kidney efficiency. Within limits one may spend as much time as is necessary to accomplish these ends before advancing to the second stage.

As in operations upon the prostate, a great deal of the mortality attending lithotomy has been due to sepsis of the wound spreading and extending into the prevesical space. Until very recently the second stage has been utilized as an insurance against this complication. The usual suprapubic incision down to the bladder wall was made and the wound packed with acriflavine gauze to stimulate a protective wall of granulation so that after seventy-two hours, when this wall has been established, one may return for the third stage or the incision of the bladder wall and removal of the stone either intact or after crushing. If advisable an obstructing prostate may be removed at the same time.

More recently we have employed only two stages, finding that packing the prevesical space with sulfanilamide crystals and closing the wound lightly around a large cystotomy tube controls the contamination nicely and permits earlier heal-

ing and lower morbidity. Careful attention to fluid balance, blood chemistry and the oral administration of the sulfonamides pre- and postoperatively is quite essential. It should be borne in mind, as has been pointed out many times, that a large calculus, unless it formed about a foreign body, has grown from small size because some obstruction was present which prevented its passing. The obstruction must be located and remedied if we would prevent a recurrence.

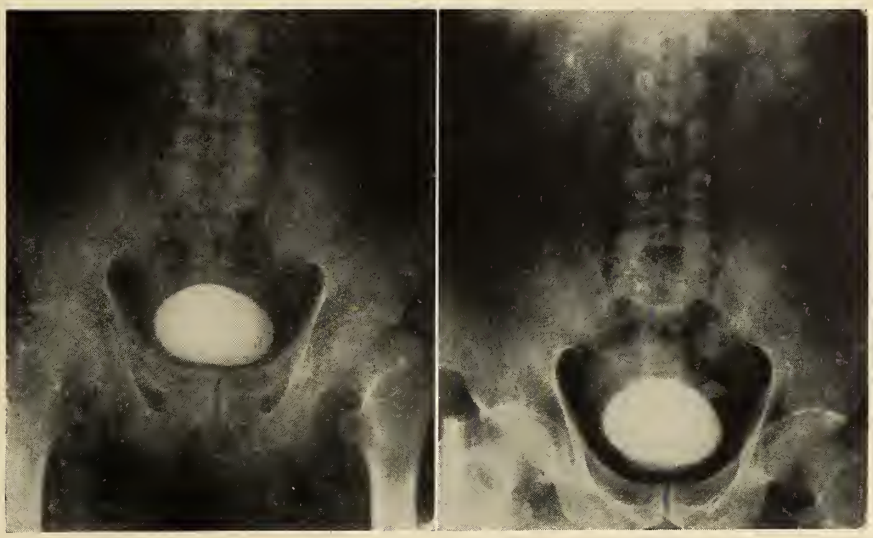


Fig. 1. *A*, Flat film showed the presence of the large stone. *B*, Intravenous pyelogram showed the stone and small diverticula.

Stones weighing over 100 grams are rarely reported. Randall[16] in 1921 reported a case of a giant vesical calculus and from a painstaking examination of the literature concluded that this giant calculus, chiefly composed of phosphate of calcium, was the largest bladder stone ever removed from a living patient. In this case a lithotomy was performed without injury to the peritoneum, but the patient died 36 hours after operation. On delivery the stone weighed 64 ounces, or exactly four pounds, but at present weighs 3½ pounds, its longitudinal circumference being 48 centimeters and its greatest horizontal circumference 40 centimeters. In the Grant Medical College, Bombay, India,[5] is the case of a vesical calculus weighing 30 ounces, 96 grains. It is the size and shape of a small coconut, was chiefly composed of uric acids and urates, and is purported to have been removed from the bladder of a twenty-five-year-old male in 1876 or 1877 by Apothecary Wright who attempted a lateral operation, then a suprapubic, and lastly resorted to lithotryptics. The patient lived twelve hours after operation.

An ancient bladder stone found in an American mummy weighed one ounce troy or 32 grams.[22] Mitchell[13] in 1915 performed a successful lithotomy for a calculus weighing 30 ounces. In 1918 a calculus weighing 385 grams was reported.[12] The stone was broken on removal. Smith[19] in 1919 successfully removed a stone weighing 38½ ounces, the largest up to that time with recovery of the patient. Anagnostidis[1] in 1937 reported the removal of a stone weighing 1200 g. and measuring 16x10x9.5 centimeters from a patient who died ten days postoperatively. Greenberg's[9] 48-year-old patient lived after removal of a bladder stone the size and shape of a baseball and weighing a little over a pound.

The case reported here is of interest because of the unusual size of the calculus and because the outcome was quite favorable.

Case Report

A fifty-five-year-old man, well nourished, was first seen on May 15, 1940, complaining of suprapubic aching, dysuria and severe burning on micturation, day and night frequency, occasional hematuria and dribbling. On one occasion retention necessitated catheterization. There was no history of gross hematuria, but the patient said his urine was always cloudy and contained much sediment. He had had these urinary symptoms for the past twenty years, but only for the last two years had they bothered him much and they had increased in severity

in the last few weeks. A single roentgenogram of the abdomen (Figure 1-A) shows the large opaque shadow in the region of the urinary bladder. An intravenous pyelogram (Figure 1-B) revealed a normal right kidney but moderate left hydronephrosis and left hydro-ureter.



Fig. 2. The stone measured 9.5 x 6.5 centimeters and weighed 289 grams.

The resultant cystogram showed the presence of a large stone in the bladder and one large and several small diverticula. He was afebrile, and his pulse was 84, blood pressure 142/102. The general physical examination was negative except for tenderness over the suprapubic area and the rectal examination revealed a general prostatic enlargement. His hematology showed: 87 per cent hemoglobin, RBC 4.45, WBC 5900, Kline negative. The blood urea was 30.38 mgs. The urinalysis showed a trace of albumen and many pus cells. P.S.P., intramuscular, for the first hour was 10 per cent, second hour 13 per cent, third 12 per cent and the total was 35 per cent for three hours. The standard urea clearance was 123.5 per cent. Our working diagnosis was massive vesical calculus with hydronephrosis of the left urinary tract. Cystotomy and removal of the stone were advised.

Operation.—On May 23 a suprapubic cystotomy was done under spinal anesthesia and the stone was found to be intimately adherent to the bladder mucosa which was separated with a great deal of difficulty and the stone removed. The bladder wall was thickened. There was some hypertrophy of the intracystic portion of the prostate and the prostatic urethra was very contracted. This was dilated with a No. 24 sound and an indwelling catheter placed in the bladder. A large drainage tube was put into the bladder and the wall closed about it. Five grams of sulfanilamide were put into the space of Retzius and this area drained with rubber tissue. The abdominal wall was closed in layers about the tube and rubber tissue. The patient was put on sulfanilamide and intravenous injections of 5 per cent glucose, 1000 c.c. every eight hours for the first twenty-four hours and then 1,000 c.c. every twelve hours. Three days later the patient's temperature rose to 103° F, he was coughing bloody sputum, the abdomen was markedly distended and gangrenous sloughing of the wound was occurring. There were râles in the base of the right lung. He was changed to sulfapyridine and a blood transfusion was given. The abdominal distention was treated with the long tube and Wangensteen suction and the operative incision was opened. The bronchopneumonia yielded to treatment with sulfapyridine and recovery was complete. On the fifth day all drainage tubes were removed. The patient was discharged on July 6, 1940. The stone (Fig. 2) removed was very hard, oblong, laminated, whitish in color, weighed 289 grams when completely dry and measured 9.5 centimeters over its greater circumference and 6.5 over its lesser circumference.

Following discharge from the hospital periodic urethral dilatations were done because of the small calibre of the prostatic urethra. On June 3, 1943, the patient was readmitted to the hospital and on June 4 transurethral resection of the prostate was done. He was discharged from the hospital on June 14, 1943, and his convalescence has been uneventful.

Conclusions

1. The successful removal of a large vesicle calculus, measuring 9.5x6.5 centimeters and weighing 289 grams, is reported.

2. Vesicle calculi weighing over 100 grams are rarely seen and removal is attended by a high mortality.

3. Management: Stabilization of water balance and blood chemistry, use of indwelling catheter, pre- and postoperative oral and local administration of sulpha drugs, and suprapubic lithotomy under spinal anesthesia are recommended in the removal of all large urinary calculi. We believe that this procedure, if universally adopted, would greatly reduce the mortality of this operation.

4. Prostatic obstruction was probably the etiological factor in this case and was relieved by transurethral resection.

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Clinical, Histopathological and Inheritance Factors in Peroneal Muscular Atrophy (Charcot-Marie-Tooth Type)

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B.Sc. in Med. U. of M., 1924. M.D., U. of M. Med. School 1926. Diplomate Nat. Bd. of Med. Examiners. Certified Am. Bd. of Neur. and Psych. Consulting Neuropsychiatrist Woman's Hospital and Harper Hospital, Detroit. Consulting neuropsychiatrist Consultation Bureau Detroit Community Fund. Lecturer in Ment. Hyg. and Soc. U. of M., 1932-36. Research Asst. Yale Univ. Inst. Human Relations '30-'33. Lect. U. of Toledo 1936-37. Lect. Psychopathology and Neurology Wayne U. Fellow Am. Psychiatric Assoc. Member Am. Orthopsychiatric Assoc., Am. Psychoanalytic Assoc., Am. Assoc. for Adv. of Science, Assoc. for Research in Nerv. and Ment. Diseases, 1929-33. Lieut. Comdr. MC-V(S) U. S. Navy Med. Corps, now on active duty.

Massive dosage of Vitamins E and B_6 administered in the treatment of peroneal muscular atrophy (Charcot-Marie-Tooth Syndrome) produced subjective improvement in this hitherto untreatable disease, in a case presentation of a patient whose genealogical history is traced through five generations of 123 individuals, twenty-six of whom were afflicted. Background history and clinical course of the disease are discussed. Heredofamilial statistics indicate a lowering in onset age in succeeding generations, increased longevity in comparison with unaffected family members. Fifty per cent of offspring of affected individuals are liable to transmission, males and females being equally susceptible.

■ Progressive types of muscular diseases are largely authenticated in accordance with the topographical distribution of atrophy or hypertrophy involved. Grouped generally, they are: Progressive muscular atrophy caused by disease of motor cells in the gray matter of the midbrain, hind brain, or spinal cord are classified as nuclear atrophies, myelotrophies or amyotrophies. Neural or neuritic atrophies are those due to involvement of motor nerve fibers. Atrophies linked with primary muscle disease are termed myopathies or muscular dystrophies.[18] In this discussion we are concerned only with a form of neural or neuritic atrophy—the heredofamilial peroneal muscular atrophy (Charcot-Marie-Tooth Syndrome), bringing up to the present a familial history of incidence of this type of muscular atrophy, first reported by Doctors Macklin and Bowman in 1926,[12] in a known history of five generations comprising 101 individuals, twenty-one of whom were affected. A case history of an additional family member is presented in this discussion.

Historical

Charcot and Marie[1] of France and Tooth[21] of England, furnished the first comprehensive clinical picture of peroneal muscular atrophy in 1886, although Virchow already had found changes in the atrophied muscles, their nerves and the spinal cord itself. Charcot, Marie, and Tooth refer to previous papers by Eulenburg,[4] Friedriech,[5] Ormerod,[15] and Osler.[16] More recently, the papers of these latter scientists have been collected by Schultze,[19] who had studied the disease in 1884. First designated as Eichhorst's disease by Dejerine, Hoffman[11] later called it "progressive neuritic muscular atrophy," and in 1891 it was changed to its present terminology.

Previous to this time "progressive muscular atrophy" indicated the type reported by DuChenne (1849) and Aran (1850); subsequently all cases having the appearance of this particular type were loosely designated as such. In 1853 DuChenne began his work of classifying muscular dystrophies. Later research by Cruveilhier and Luys contributed far-reaching progress, by proving that this disorder was the result of disease of the anterior horn cells of the spinal cord, causing DuChenne and Aran to revise their belief as to muscular origin. Charcot segregated amyotrophic lateral sclerosis from this large group of muscular atrophies in 1865. Schultze and Kahler isolated some forms of sensory anomalies, establishing the syringomyelia group in 1888. Erb established the juvenile type; Landouzy and Dejerine the facioscapulohumeral type; Charcot-Marie-Tooth the peroneal group, leaving so little of the original Aran-DuChenne type that it was declared in 1897 not to have a clinical entity.[18]

Etiology

The factor of heredity in peroneal muscular atrophy is predominant in known genealogical histories. Churchill[2] obtained records of this disease in nine generations; Haenel[7] reports thirty-two cases in four generations; Souques,[20] twenty-five in seven generations; Herringham,[10] nineteen in three; Gordon,[6] eleven in five. The "P" family of which the subsequent case presentation is a part, now shows twenty-six cases in five generations. Herringham reports that only males were affected, but that the disease was transmitted by healthy females. Raffan reports transmission through both normal and affected females. Gordon reports transmission only through affected females. In the "P" family, males transmitted the disease three times, females seven times. It is generally accepted that males are more frequently affected (Wilson, Bruce, Wechsler, Oppenheim, Hassin) than females, which is borne out in the "P" family histories which show that although males have transmitted the disease but three times in five generations, thirteen males were affected.

Onset of peroneal atrophy is usually associated with late childhood or youth, approximating the ages of ten to twenty years. Incidence of onset in the "P" family indicated a tendency for the disease to appear at increasingly younger ages in succeeding generations, as shown in subsequent tabulations. Invariably age of onset is homochronous for individual family members affected.

Symptomatology

Insidious in development, the first indication of progressive peroneal atrophy is atrophic weakness in the small extensor and abductor foot muscles, generally beginning in the abductors. Thereafter, in a gradual extension of atrophy similar to that found in spinal cases, it spreads to the extensor longus hallucis, extensor communis digitorium and peronei, producing in combination with atrophy of small foot muscles, a mild equinovarus deformity and "pied-engriffe." Flexor muscles of the ankle appear to remain unaffected for the longest period, although they too succumb as do the calf muscles.

Coincident with onset of small foot muscle atrophy, particularly when the disease begins in childhood, is the tendency to develop hammer toes and pes cavus, sometimes eliciting no complaint except the necessity for higher arched shoes. The arches slowly become higher with hyperextension of metatarsophalangeal joints coupled with flexion of digital joints. With the slow spreading of the atrophy, all muscles below the knee joint are affected, foot drop develops, and the patient finds difficulty in lifting his feet in normal walking, developing the necessary compensatory "steppage" gait.

Atrophy in the Charcot-Marie-Tooth type of peroneal disease seldom extends above the knee joint, being confined to a gradual wasting of muscles through the years to where the patient exhibits the typical "stork legs," with accompanying complete loss of muscle power in the lower extremities. In the case of the "P" family reported by Macklin-Bowman, there is shown in Figure 4 photographic evidence of advanced atrophy with an extremely sharp line of demarcation at the knee joint between healthy and atrophied muscles, and beginning typical claw-like foot development. However, in advanced cases, the muscles of the thigh eventually may become involved. Similarly, the upper extremities may run the same course of atrophy, with beginning changes in the thenar, hypothenar and interossei muscles, producing a claw-like hand. Flexors and extensors of the forearm gradually give way, although the supinator longus seldom becomes involved in the wasting process.

Muscles of the face, trunk, and proximal musculatures are generally free from attack, although Hoffman, Van Bogaert,[23] and Wohlfahrt[26] report isolated cases involving these areas.

Muscle power, while gradually and inevitably decreasing, may be preserved for a long time, enabling the patient to remain ambulatory despite his "stork legs." It is noted in some cases that the muscles showing the most apparent atrophy are not always the weakest and again, that those muscles showing earliest wasting do not always show greatest and most progressive atrophy. In addition to the atrophy there are vasomotor disturbances in the extremities; cold and clammy hands and feet, cyanosis, mottled appearance of skin, changes in nails, and Hatch[9] and Sachs[17] report atrophy of bone.

From the standpoint of reflex involvement, absent ankle and knee jerks are noted, although the latter are sometimes preserved throughout the long course of the disease, because of the healthy tone of thigh muscles. Gastrocnemius involvement diminishes or entirely abolishes ankle jerk.

TABLE I. CLASSIFICATION OF TYPES AND SYMPTOMS

GROUP 1. PROGRESSIVE NUCLEAR ATROPHIES, AMYOTROPHIES, MYELOPATHIES	CARDINAL SYMPTOMS
1. Aran-DuChenne type (spinal adult) 2. Werdnig-Hoffman type (early infantile hereditary) 3. Chronic poliomyelitis (not true progressive) 4. Fazio-Londe type (progressive bulbar paralysis of childhood) 5. Adult progressive bulbar form 6. Bernhardt type (mixed spinobulbar) 7. Chronic progressive opthalmoplegia	Onset late in life, rarely in early childhood. Not hereditary as a rule. Wasting first in upper extremities, leg type rare. Hypertrophy does not occur. Fibrillary twitchings. Reaction of degeneration often present in affected muscles.[18]
GROUP 2. PRIMARY MYOPATHIES OR MUSCULAR DYSTROPHIES	CARDINAL SYMPTOMS
1. Pseudohypertrophic type 2. Erb (juvenile type) 3. Landouzy-Dejerine (facioscapulohumeral type) 4. C. Hoffman (bulbar form) 5. Gowers (distal type) 6. Mixed and transitional types	Onset in early life. Generally hereditary, family trouble Wasting or hypertrophy begins in the lower extremities. Hypertrophy frequent. No fibrillary twitchings. Reaction of degeneration rare (qualitative electrical changes)[18]
GROUP 3. PROGRESSIVE NEURAL (NEURITIC) MUSCULAR ATROPHY	CARDINAL SYMPTOMS
1. Charcot-Marie-Tooth (peroneal form or leg type) 2. Dejerine-Sottas; Marie (hypertrophic interstitial neuritic type (tabetic) 3. Sainton (arm type) 4. Transitional and mixed forms	Onset anywhere from late childhood to middle age. Hereditary Wasting begins in lower extremities Hypertrophy absent Fibrillations Reaction altered, not as extreme as Group 1, not as mild as Group 2. Diminished quantitatively, altered qualitatively.

Arm and skin reflexes are relatively slightly affected. There are fibrillations, qualitative electrical changes up to an incomplete R.D. Oppenheim[14] reports a case in which marked modification of electrical excitability extended over the entire body, while atrophy was present only in the lower extremities. Mild sensory disturbances are noted—diminution in all forms, or complete loss of sensibility to touch, pain, temperature, particularly in distal areas. Vibration sense is most always impaired. Mild ataxia has been noted. Pain associated with peroneal atrophy is rather rare, according to Wechsler,[24] although Oppenheim, Sachs, Hausman, Wilson and Bruce report pain as an adjunct of the clinical syndrome. Marinesco reports extremely severe pain and marked hypaesthesia in a few cases.

The disease runs a chronic course, is not in itself fatal. Many affected individuals continue with their occupations while their legs become progressively atrophied and useless. Considering the longevity of members of the "P" family whose age at time of death is known, the average death age of affected members is sixty, while the unaffected deceased members had an average age at death of forty-seven. Wechsler reports that the disease frequently remains stationary and that there are remissions, sometimes of twenty-five years' duration.

Pathology

It is rather difficult to correlate the clinical symptoms of peroneal muscular atrophy with underlying pathologic conditions. It is undoubtedly heredodegenerative in nature. Atrophic lesions in ventral horn cells and dorsal root ganglia are most constantly in evidence. Degenerative lesions are usually found in ventral roots, ventral horn cells, peripheral nerves and muscles, corresponding to clinical sites. Analogous changes on the afferent side are equally common—in dorsal roots and ganglia, in the tracts of Goll and columns of Clarke. Pyramidal paths have occasionally been affected. Mainly in the lumbar enlargement, but also in the cervical, motor cells gradually decay and disintegrate, glial overgrowth ensues, and

interstitial reaction follows atrophy of axons and myelon sheaths in roots and nerves. Muscle lesions are necessarily of secondary nature.

Since the longest axons usually suffer first in decay of neuronic structures, this may account for primary onset in the lower extremities. The Goll degeneration is described as the result of axonal atrophy from the root ganglia of lower

Differential Diagnosis

Criteria for diagnosis of the Charcot-Marie-Tooth type of peroneal atrophy are quite definitely established, permitting accurate recognition in most cases. However, since this neuritic type of atrophy embodies some of the characteristics of each of the remaining two large general groups of progressive muscular atrophies:

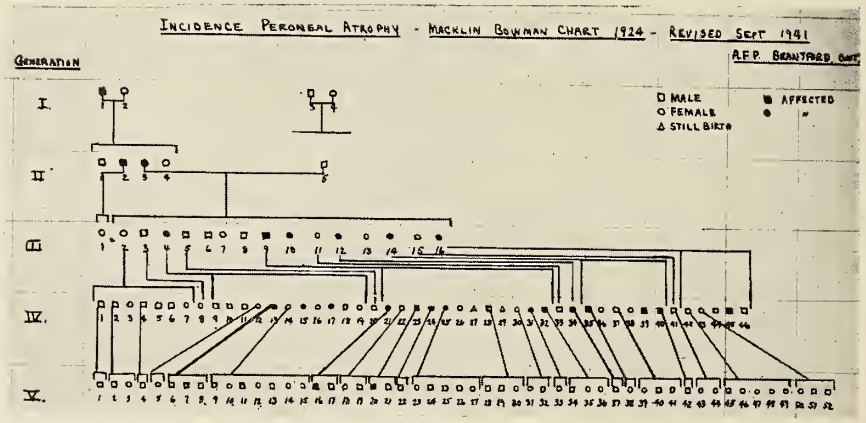


Fig. 1. Genealogical Chart of "P" family, showing incidence of peroneal atrophy (Charcot-Marie-Tooth type).

limb segments.[25] Spiller summarized the pathology as follows:

"The lesions are sclerosis of the posterior columns of the cord, slight degeneration of both pyramidal tracts (Sainton), with integrity of the anterolateral columns in some instances (Marinesco), alteration of the columns of Clarke, atrophy of the cells of the anterior horns of the cord, alteration of the peripheral nerves, which may be slight, and of the intramuscular branches, atrophy of muscle fibers, and chronic meningitis (Dejerine and Armand-DeLille). The nerve trunks, the cutaneous sensory nerves, and the anterior and posterior nerve roots, with slight exception, may be normal."

Muscles of the atrophied areas are in process of granular degeneration, with proliferation of nuclei of the perimysium, while other fibers degenerate entirely and are replaced by sclerotic scar tissue. Some fibers may remain unaffected and retain their striation.[8] The sclerotic scar tissue has been characterized by Nielsen as a somewhat hard connective tissue which affords some support to the joints, thereby providing a pathologic basis for the relative absence of disability in individuals suffering from this disease.

(1) the progressive nuclear atrophies and (2) primary myopathies or muscular dystrophies, it might be well to include the classification of types and symptoms as shown in Table I. (See page 221.)

The tabulation embraces cardinal points in differential diagnosis that can be used as reliable criteria in the majority of cases. Hereditary factors, deviation in electrical reactions and fibrillary twitchings have been reported at variance with this classification in isolated cases. Of these cardinal symptoms, only a few are, without variance, present in one or the other type of progressive muscular disease, and we must be guided by a general agreement of symptoms rather than by any single one. Establishment of reliable diagnosis must include an evaluation of the allied types of disorders, which include: myasthenia gravis; Oppenheim's amyotonia congenita or myotonia congenita; Thomsen's myotonia congenita, myotonia atrophica; amyotrophic lateral sclerosis; syringomyelia; and family periodic paralysis.

Known genealogical history, symmetrical atrophy of distal peripheral segments, insidious onset from late childhood up to middle age, serve

EXPLANATION OF CHART

Generation	Male Affected	Male Unaffected	Female Affected	Female Unaffected	Age at Onset	Age at Death		Age
						Affected	Unaffected	
I	1				?	70		
II	2				Late in Life	Old Age		
II			3		40	73		
II				4			80	
III				1			61	
III				2			77	
III			4		?	50		
III		6					66	
III				7			75	
III		8					31	
III	9				25	42 (Twin to III, 10)		
III			10		18	66 (Twin to III, 9)		
III				11			40	
III			12		18	66		
III				13			Infancy	
III			14		20	74		
III				15				77
III			16		20	48		
IV		1					54	
IV		2						70
IV				3				68
IV		4					36	
IV		5					44	
IV		6					25	
IV				7				55
IV		9					Infancy	
IV		10					Infancy	
IV		11					18	

EXPLANATION OF CHART (Continued)

Generation	Male Affected	Male Unaffected	Female Affected	Female Unaffected	Age at Onset	Age at Death		Age
						Affected	Unaffected	
IV				12			61	
IV			13		16			62
IV				14			38	
IV			15		24			58
IV				16			Infancy	
IV			17		14			54
IV		18					28	
IV		19						46
IV		20						64
IV			21		15			61
IV		22						59
IV	23				30			57
IV			24		?			52
IV			25		?			50
IV				26				47
IV†								
IV		28						46
IV‡								
IV				30				44
IV			31		?			39
IV	32				31			36
IV		33						56
IV	34				25			58
IV	35				35			51
IV		36					23	
IV		37						49
IV				38			Infancy	
IV	39				12			43
IV	40				12			40
IV		41						56

†27, stillbirth, sex unknown.
‡29, stillbirth, sex unknown.

EXPLANATION OF CHART (Concluded)

Generation	Male Affected	Male Unaffected	Female Affected	Female Unaffected	Age at Onset	Age at Death		Age
						Affected	Unaffected	
IV		42						49
IV				43				46
IV		44						44
IV	45				18			42
IV		46						40
V		1						37
V		2						34
V				3				33
V		4						29
V				5				35
V		6						33
V	7				18			26
V*								
V				12				26
V		13				(Unknown)		
V				14		(Unknown)		
V	15				12			30
V		16						27
V		17						27
V				18				25
V	19				23			28
V		20						26
V		21						24
V		22						18
V				23				19
V		24						20
V		25						24
V		26						22
V				27				29
V		28						27
V**								

*8, 9, 10, 11, living, ages unknown.
**29 to 52, exact ages unknown, all under 26, all living and well.

as sufficient preliminary recognition of the Charcot-Marie-Tooth type of peroneal atrophy. The relative absence of disability distinguishes it from amyotrophic lateral sclerosis, with its marked disability.

Anterior poliomyelitis differs chiefly by irregularity of distribution; the Charcot-Marie-Tooth type is always symmetrical.

Similarly, Friedriech's ataxia can be ruled out; its wide clinical range (mental deterioration, ataxia, loss of knee jerks, Babinski responses, nystagmus) does not appear in the Charcot-Marie-Tooth type. The lumbar type of progressive muscular atrophy manifests itself later in the life cycle, without familial factors, and with no sensory disturbance.

The Charcot-Marie-Tooth type differs from the rare distal myopathy by fibrillation, general presence of knee jerks, and sensory symptoms.

The Dejerine-Sottas childhood type of hypertrophic neuritis is sometimes confused with the Charcot-Marie-Tooth type, since the latter also develops in childhood, with similar indications of neuritis. However, the Dejerine-Sottas is differentiated by hypertrophic and tender nerves, marked sensory loss, pain, while the Charcot-Marie-Tooth type does not show tenderness except in extremely rare cases, although thickening of the nerve may be present.

Because of its heredofamilial nature, a basic knowledge of the genealogical history is of extreme importance in evaluating this condition. In the presentation of this most recent clinical history of a member of the "P" family, we are fortunate in having access to a fairly complete familial picture. For much of this material I am indebted to Doctors Madge Thurlow Macklin and J. Thornley Bowman of London, Canada, particularly for their presentation of the case history of "A.P.," brother of the patient whose case I present in this discussion, and I wish to express my deep appreciation to them.

Genealogy of the "P" Family

The chart of this Canadian family is herewith presented (Fig. 1), covering five generations comprising 123 individuals, twenty-six of whom (thirteen males, thirteen females) are affected. The first known member of this family, represented as I 1, on the chart, came to Canada when a young man. He was an orphan and no knowledge of his antecedents is available.

Since Doctors Macklin and Bowman published their research findings in 1926 in the case presentation of IV 37—four additional instances of affection in the "P" family have been revealed:

IV 24—female, age at onset, not known
IV 32—male, age at onset, 31
V 7—male, age at onset, 18
V 19—male, age at onset, 23

No new cases of affection have been reported since 1925 in members of the third generation; two new cases developed in the fourth generation as noted above. One death of affected individual, IV 12, occurred since 1925 at age of sixty-one years. That the disease is showing increasing incidence in the fifth generation is indicated by the report of two additional cases, noted previously. Known members of the fifth generation is shown as fifty-two, with three affected. Little is known of twenty-four individuals (Numbers 29 to 52), except that they are under twenty-six years of age, and apparently well. While the chart would indicate a decrease in the disease in the fifth generation, it must be borne in mind that with the tendency for development of peroneal atrophy in the "P" family to occur later in life than is generally accepted by medical science (ten to twenty years), there will undoubtedly develop a higher incidence than is now evident.

Macklin and Bowman concluded that an affected individual is liable to transmit the condition to half his offspring. From the standpoint of liability of transmission by affected persons, the chart indicates that all affected persons do so. Of twenty-five affected individuals, ten have transmitted it, or a percentage of 40. Members of an affected family who themselves do not show clinical evidence of the disease, can and do, transmit it. This is supported by evidence of II 3, a woman who did not develop the disease until forty years of age, having produced a family of fifteen children—six of whom were affected. At least ten of her children, perhaps more, were born before she was forty; therefore, before she exhibited any manifestation of hereditary taint. Had she died before reaching forty, it would have appeared that there had been a remission of the disease for one generation.

Considering peroneal atrophy from the angle of sex transmission, it is shown that thirteen males and thirteen females are affected; the males transmitting it three times, the females

seven times. Macklin and Bowman stated in 1926: "Of the eleven females with peroneal atrophy, two had no children, three have children young enough to show it. Thus, 100 per cent of the females whose capacity for transmission we can verify, have passed it on."

This is verified further in the additions to this chart as of 1942. Of thirteen females with peroneal atrophy, three have no children; five have children young enough to show it (V 6, 7, 8, 16, 17, 22, 23, 24, 25, 26, 27, 33). Two of these five women have now transmitted to V 7 and V 19. Of the remaining children in the fifth generation by the three remaining mothers, one is thirty-three years old; one is of unknown age, eleven vary in age from eighteen to twenty-seven. Since these unaffected offspring cannot be considered as free of the hereditary condition because of their ages, it can be assumed that a ratio corresponding to previous percentage of affect in the family will ensue.

Average age of onset for all those affected is twenty-one years. If reviewed by generations it is shown as follows: Average age at onset in second generation, forty years; third generation, twenty-one years; fourth generation, twenty years, and in the fifth generation, eighteen years. This tends to indicate a lowering in onset through succeeding generations.

From the standpoint of longevity of affected persons, known records indicate that those affected have a longer life span than unaffected members. In 1925, average age at death of affected members was fifty-eight; of unaffected members, fifty-five. The family records as of 1942 show several changes, some because of deaths in the interim, others through correction of earlier reported life spans of several members by the family historian. We now have records of ages at time of death of seven affected members, the average at death being sixty years. Of the known fifteen unaffected, the average age at death is forty-seven. This is exclusive of stillbirths and deaths in infancy. One member lived fifty-four years after onset, one forty-eight years, one thirty-three years, and one seventeen years. Of living affected members, two are living forty-six years after onset, varying down to five years after onset.

Macklin and Bowman state that peroneal atrophy is due to the presence of a unit character, i.e., one that is carried within one chromosome and distributed to half of the mature germ cells; as a result being present in half the offspring. With 40 per cent of the "P" family affected, and with probability of a higher percentage as the family grows older, it is assumed that peroneal atrophy is due to a unit character, ratio approximating 50:50.

Peroneal atrophy is not sex-linked and recessive. If such were the case, the affected father would have no affected children, but his daughters would carry it latent, transmit it to their sons, who show it, and in turn transmit it to their daughters who would carry it latent. An affected father does not transmit a sex-linked recessive factor to his son. Since the first known member of the "P" family transmitted it to both son and daughter in active form, this type of inheritance must be dismissed. The disease is not recessive, since it has not appeared in children of unaffected parents. It is dominant, not sex-linked. To conclude that it is dominant, males and females exhibit it equally, transmit it equally; 50 per cent of offspring show it on the average, and it does not appear in families of unaffected parents.

This family shows no improvement in the course of the disease; it runs a gradual but inevitable course. Recent therapeutic measures have been observed and recorded which will be discussed later.

Case Presentation

H. P., male, aged forty-two, came to my office in 1940 for consultation; a well-developed, healthy looking individual, with the exception of difficulty in walking, and supporting himself with the assistance of a cane. He is a keenly intelligent individual, holds a responsible sales-directing position and leads an active life. Examination revealed wasting of muscles and atrophic skin below the knee, marked erythema over dorsum of both feet and toes. Further clinical and familial investigation revealed that he was suffering from peroneal atrophy of the Charcot-Marie-Tooth type.

History.—Patient has had insidious progressive atrophy of muscles of lower extremities since he was twelve years of age. However, he did not experience ambulatory difficulty until he was twenty, when he started to stumble. Thereafter, it became increasingly difficult for him to walk, bilateral foot drop developed, and he developed the customary "steppage" gait. His legs frequently buckle when negotiating stairs. He had experienced no pain, has not noted twitching in muscles, and sensation is present in both extremities. He has difficulty in keeping his feet warm, and observed that wounds heal poorly in the affected areas.

Family History.—Patient is IV 39 of the chart (Fig.

1). He is one of a family of six. Siblings: one sister, four brothers—two brothers being affected. The case reported by Doctors Macklin and Bowman in 1926 is the brother of this patient. Genealogical history shows that patient's mother, four of her sisters and a brother, patient's maternal grandmother and great grandfather suffered from peroneal atrophy. Patient is married but has no children.



Fig. 2. Anterior aspect of patient "H.P." showing atrophy of lower extremities, marked erythema of both feet.



Fig. 3. Posterior aspect of patient "H.P." indicating well-developed male body above knee, marked atrophy below.

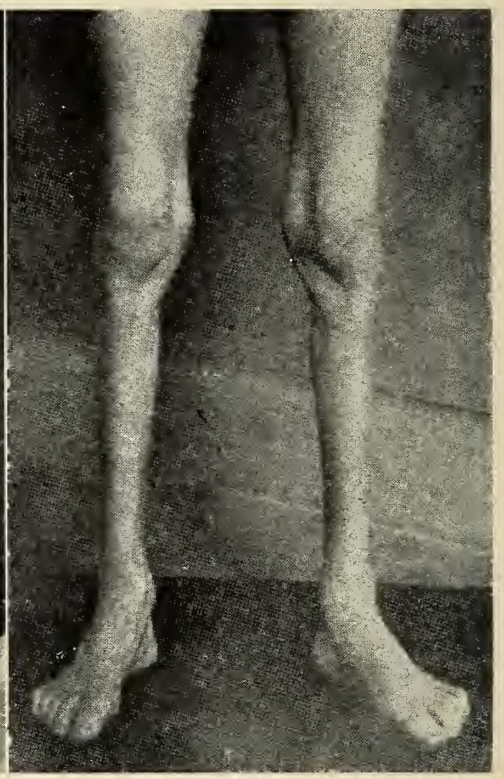


Fig. 4. Photograph of patient's brother "A.P." reported by Doctors Macklin and Bowman in 1926, showing definite line of demarcation at knee joint between atrophied and healthy muscles.

Clinical Course.—This man has been under my care intermittently since 1940, and in March, 1941, a biopsy of muscle was performed at Harper Hospital. Physical examination at that time, with the exception of lower extremities, was essentially normal. Skin was normal, with exception of atrophied area of lower limbs, and erythema of feet. Head, eyes, ears, nose and throat normal; heart and lungs normal; BP 125/84, temperature, pulse and respiration normal. He has slight weakness in abdominal muscles, and protuberant appendectomy scar.

Lower extremities exhibited severe atrophy of all muscles below knee, lesser atrophy in the lower third of thighs. No elasticity of Achilles tendon. No bone anomalies. Upper extremities showed no evidence of muscle atrophy. Reflexes: absent knee jerks and Achilles jerks. No clonus or Babinski. Upper abdominals present, lower abdominals absent bilaterally. Umbilicus moves upward in effort to sit erect unaided.

No sensory disturbance except dullness of sensation. Blood Chemistry: Sugar .100 per cent, NCN mgm. 38.5; Kahn, negative. Urinalysis: Specific gravity, 1.016, yellow, no casts, negative.

Under local anesthesia a considerable strip of muscle was removed, one incision over upper part of the peroneus longus, the other over nerve ending area. Muscle exposed exhibited a dull, brownish color.

Figure 2 shows anterior aspect of progressive muscular atrophy below knee, and marked erythema of both feet. Patient does not yet exhibit the claw-like foot structure characteristic of advanced Charcot-Marie-Tooth disease. Figure 3 shows posterior aspect, the well-developed male body above knee, marked atrophy below.

Laboratory study of the biopsied muscle tissue by Dr. Gabriel Steiner of the Brain Disease Registry at Wayne University, revealed extreme muscular atrophy, loss of contour of muscle fibers, with altered staining properties of cytoplasm, increase of sarcolemmal nuclei, and the appearance of hyaloid, globoid bodies indicating a peculiar process of muscular atrophy. Most of the muscle tissue is replaced by fat cells; the few remaining fibers do not show striation, and there is marked increase of collagenous fibrous tissue between remaining degenerated muscle substance. Microphotographs of atrophied muscle tissues, using various stains are shown in Figures 5, 6, and 7.

In Figure 5, contour of muscle fibers has been changed markedly with swelling and contraction.

There are irregular formed masses mixed with very numerous small hyperchromatic nuclei and a few larger nuclei which are poor in chromatin. Remnants of striation are extremely rare.

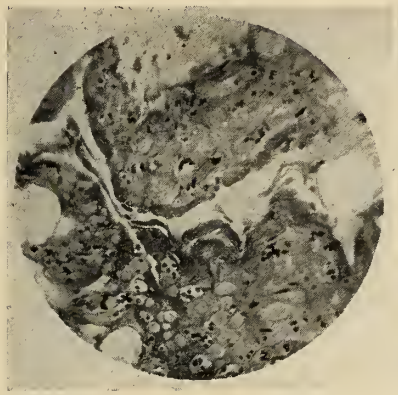


Fig. 5. Microphotograph, using von Gieson stain, showing changed contour of muscle fibers, irregular formed masses mixed with very numerous small hyperchromatic nuclei, and a few larger nuclei poor in chromatin. (Enlarged 125 times.)

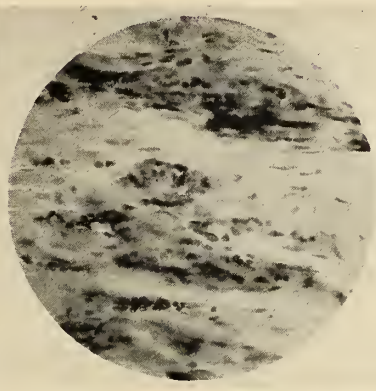


Fig. 6. Microphotograph showing sarcolemmal cells partially filled with reddish substance. Glycogen particles show very fine granules, usually in one peripheral part of cell, running parallel with direction of destroyed fibers. (Enlarged 175 times.)

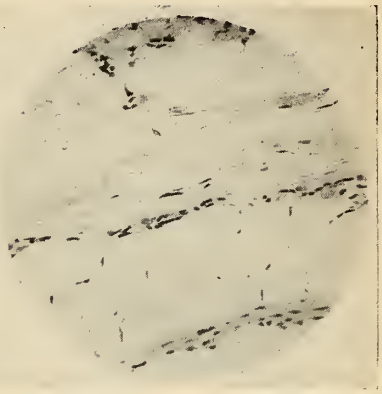


Fig. 7. Microphotograph shows very pale and metachromatic muscular substance, a number of globular homogeneously stained corpuscles with or without a small nucleus at the periphery. Larger oval corpuscles show accumulation of seven or more nuclei at one end. Numerous mast cells are present in the connective tissue. (Enlarged 125 times.)

Figure 6 shows a number of sarcolemmal cells partially filled with reddish substance. These glycogen particles show very fine granules usually in one peripheral part of the cell running parallel with the direction of the destroyed muscle fibers.

Figure 7 shows very pale and necrotic metachromatic muscular substance. Using this stain, there is shown a number of peculiar glomular homogeneously stained corpuscles with or without a small nucleus at the periphery, with some vacuoles in it. The larger oval corpuscles show an accumulation of seven or more nuclei at one end, giving an appearance of a peculiar giant cell. There are numerous mast cells present in the connective tissue.

Course of Treatment

Until recent years, medical science held out no hope whatever to the victim of peroneal atrophy, other than alleviation of subjective discomfort, and the use of orthopedic appliances. Although we must approach any course of treatment forearmed by very guarded prognosis in this hitherto hopeless disease, recent developments in the field of Vitamin E therapy offer a faint ray of hope where none has existed.

Clinically Vitamin E deficiencies have been largely identified with dysfunction of the reproductive system, and concordantly, the greatest achievements have been made in treatment of such disorders. Further investigation of such Vitamin E deficiency in rats revealed (1) retardation of growth in young animals accompanied by atrophy of muscles and paralysis of extremities and (2) degenerative lesions of the spinal cord in adult animals, with destruction and loss of function of the peripheral nerves. Bicknell of England and Wechsler reported simultaneously



Fig. 8. Lateral aspect of patient "H.P." showing incision for biopsy of muscle, lateral view of atrophied areas.

successful treatment of several cases of amyotrophic lateral sclerosis with Vitamin E in 1940. Subsequent investigation of these cases widened the scope of Vitamin E therapy in the treatment of other atrophies. Since this is a pioneer effort in a field where previously attempted therapeutic efforts have resulted in failure, we cannot make the dramatic announcement that Vitamin E therapy is the magic panacea for the treatment of these most stubborn neuromuscular diseases.

This is further borne out in a statement from

the Mayo Clinic (August 13, 1941) reporting progress in the administration of Vitamins E and B_6 to a total of twenty-seven patients, eleven of whom suffered from amyotrophic lateral sclerosis; five with progressive muscular atrophy; nine with progressive muscular dystrophy; one with Charcot-Marie-Tooth type of muscular atrophy; one with localized panatrophy. This list includes eighteen patients who had received prolonged and vigorous treatment; those with amyotrophic lateral sclerosis were treated for periods ranging from six weeks to eleven and a half months; those with progressive muscular atrophy, from four to ten months; muscular dystrophies five and one-half to nine months. In the words of the authors (Drs. L. M. Eaton, H. W. Woltman, H. R. Butt): "At the time of completion of our study, no patient who had amyotrophic lateral sclerosis or progressive muscular dystrophy was known definitely to have benefited. We have found no conclusive evidence that Vitamin E alone or in combination with B_6 or other vitamins is of benefit in amyotrophic lateral sclerosis, progressive muscular atrophy or progressive muscular dystrophy." Four of these patients with muscular dystrophy gave written testimony that they showed improvement; examination of two of them, however, revealed it to be subjective only.[3]

Mr. H. P. was started on vitamin therapy in March, 1940, receiving massive dosage of Vitamins E and B_6 orally and intramuscularly. He was placed on a moderate reducing diet to hold his weight to normal level without loss of energy. Adrenal cortex therapy was instituted in an attempt to effect further permeability of circulation in skeletal muscles and blood capillary walls, with the hope that the atrophied extremities might benefit from the stepped-up circulation. Light and heat treatment was prescribed to relieve vasomotor symptoms and to make the patient as comfortable as possible. Glycine was given to provide added energy by increased protein metabolism.

The results of this treatment can best be ascertained from the patient's written statements:

"I have been faithfully following the regimen of vitamins, Cortin, and glycine and my general condition is good. Weight is down to 150 from 165 pounds in April, with some gain in agility; as a result I imagine less general fatigue. Walking continues difficult; however, I can't say that I notice any muscular grain, and no marked changes beyond foot movements previously discussed. Due to lowered weight or other causes, mobility is somewhat improved. Hardly a week passes that I do not successfully attempt some small activity previously abandoned. Examples: I can mount a step about three inches high in the office washroom using only my left hand for support, where I previously used both hands. It is not yet a natural easy motion, but is becoming habitual. I can step off the final step of the office stairs using only my right hand on the rail. Previously, I turned sidewise and used both hands. I can get to a standing position out of all kinds of chairs much more easily. I made a 600-mile trip in Ohio with one of our salesmen, calling on a number of customers and doing considerable stair climbing. I would have dreaded such a trip last March, but I came back feeling fine. I don't think I can stress strongly enough the encouragement resulting; I do not want to seem too encouraging nor to see improvement where it doesn't exist."

Since subjective improvement is the best we can hope for with our present facilities in treating peroneal atrophy, our conviction that it should be eradicated from society is not altered. Education in contraceptive measures among family members where such known affliction exists is not only fair to them, but to the possible future generations. This is the only course open to us in controlling the spread of this disease.

I wish to take the opportunity to express my appreciation to Dr. Gabriel Steiner of Wayne University, Dr. Plinn F. Morse, chief of the department of pathology, and Dr. Robert Kidner, chief of the department of orthopedics, Harper Hospital, for their coöperation in making this study possible.

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Rhinolith in a Child

By Frederick T. Munson, M.D.
Detroit, Michigan



Frederick T. Munson, M.D., Chief of Staff in Ophthalmology and Otolaryngology at Alexander Blain Hospital, Detroit, Michigan, from 1921 to present time. B.S., 1912, and M.D., 1914—University of Michigan. Staff member Grace Hospital, Department of Otolaryngology, 1919-1924. Consultant in Otolaryngology, Receiving Hospital, Detroit. Member, American Academy of Ophthalmology and Otolaryngology; member of numerous local and national medical societies.

Report of a case of a twelve-year-old girl, who had a large rhinolith of the right nasal cavity. This was removed under general anesthesia through the anterior nares. Section revealed a wad of paper as the "core" of the calcified mass.

■ The formation of nasal calculi is becoming rather rare; in fact, a review of the literature reveals only 21 cases reported between 1925 and 1936 and a dozen cases reported since then. In 1921 Key-Aberg[1] collected over 300 cases from the literature. Stauffer[4] believes this decrease in incidence is due to better nasal hygiene and more frequent examinations. Nasal concretions apparently are more frequently found in adults than in children and occur more often in the female than in the male. Snyder and Feldman's[3] case, that of a child six years old, is the youngest patient on record.

Nasal concretions are usually classified as (1) "true" rhinoliths, that is, those formed around a nucleus of blood, mucous or scabs, and (2) "false" rhinoliths, that is, those formed around a bead, button, bean, piece of coal or some such foreign body. They vary in size from that of a small granule to large masses which completely obstruct the nasal chamber. The largest rhinolith recorded weighed 110 grams.[4] Some of these large stones have to be removed by lateral rhinostomy.

Some authors believe that frequent head colds may be a factor in the formation of a rhinolith. Polisar[2] contends that the salts originate from the tears and to a lesser extent from the nasal secretions. In the differential diagnosis of rhinolith, osteoma, syphilitic sequestration, neoplasm, bony necrosis, and fibrosis of the turbinal bodies must be considered. The condition is usually one of long standing, is always unilateral, and no recurrences have ever been reported. Stauffer's[4] case is the most recently reported. This was a "true" rhinolith which apparently had existed for a period of fifteen years, and the symptoms which brought the patient to a physician were entirely referred to the ear.

In my own experience I have seen only two of these concretions. The first occurred in an adult a number of years ago. The second was found in a girl aged twelve, whose history follows:

The child was first seen on January 8, 1943, because of a history of foul drainage from and soreness in the right side of the nose for a period of two years. However, she was able to breathe through the right nostril at all times, even though the condition was aggravated during the winter months. She had had scarlet fever and diphtheria at the age of five. Her past history was otherwise irrelevant and the child was in good health except for the present complaint.

Upon examination the maxillary sinuses were found to be dark to transillumination, and the right nostril was filled with a gray, calcified substance some 2x1 cm. in size. Roentgenograms of the sinuses were not obtained. The tonsils were large and hypertrophic and the adenoids were moderately enlarged. The ear canals were clear and the drums entirely normal. A diagnosis of chronic tonsillitis, chronic suppurative maxillary sinusitis and rhinolith of the right nares was made.



The rhinolith measured 2 x 1.3 x .8 cm. and was composed of a hard shell of calcium carbonate formed over a wad of brown paper.

On January 9 the right nasal chamber was explored under ether anesthesia. The rhinolith was lying in the inferior and middle meati; it was kidney shaped, very hard and about 2 cm. long. Apparently the stone had pushed the septum over to the left and caused some atrophy of the lower turbinate against which it was

From the Department of Otolaryngology, Alexander Blain Hospital, Detroit, Michigan.

impinged. It was removed through the anterior nares by means of a curved curette which was used as a hook in obtaining purchase on the rhinolith. The right maxillary sinus was explored with a trochar and a moderate amount of pus evacuated. Tonsillectomy and adenoidectomy were performed, and the tonsils found to be very large and reddened, deep crypts being present bilaterally. The adenoids almost completely filled the nasopharynx.

The calculus removed from the nose measured 2x1.3 x.8 cm. and was found upon chemical analysis by Dr. Donald C. Beaver to be composed of calcium carbonate. When cut it was found to be a "false" rhinolith, having formed a thin but very hard shell over a core consisting of a wad of paper.

The patient was discharged on January 10, completely recovered.

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MSMS

THE DOCTOR'S HEART

Coronary arterial disease has been referred to many times as the doctor's disease. The pathologic changes produced in the heart by sclerosis of the coronary vessels are responsible for the doctor's heart. That this term is not a misnomer can be substantiated by the vital statistics reports of the last few years. In 1942, for example, there were 3,329 deaths of doctors listed in *The Journal of the American Medical Association.* The causes of these deaths have been broken down in an editorial which appeared in the *J.A.M.A.,* January 13, 1942. Heart disease was responsible by far for the greatest number of deaths amongst doctors. Of those physicians who died, death in 627 instances was reported as coronary thrombosis and occlusion with other coronary diseases, and angina pectoris listed to the number of 143. Eight hundred and thirty-eight deaths were the result of "disease of the heart and myocardium." There were listed also a considerable number of deaths as result of arteriosclerosis and its end results. Presumably a goodly number of these patients had coronary arterial disease as some of the diagnoses are quite inexact, indefinite and inconclusive, being reported merely as cardiovascular renal disease to the number of 217.—J. H. Musser, M.D., *Ohio State Medical Journal,* February, 1944.

Chordoma: Report of a Case

By William E. Keane, M.D.

Detroit, Michigan



M.D., Wayne Medical College 1902, Professor of Urology, Wayne University College of Medicine, Attending Urologist Providence and Receiving Hospitals, Consulting Urologist United States Marine Hospital and Deaconess Hospital, Detroit.

The literature of chordoma is reviewed and the diagnosis and treatment discussed, together with report of one case which produced unusual bladder disturbances.

■ A review of the literature concerning chordoma discloses considerable conflict and disagreement among various observers in regard to the incidence and results from treatment of these cases.

Chordoma is a comparatively rare and invariably fatal tumor which arises from the remnants of the fetal notochord. Nacha and Laskey,[3] state that the lesion is not as rare as was formerly believed. They point out that roentgenographic diagnosis is easily made, and add, that it is surprising that urologists do not report these lesions more often since the urinary symptoms are often the first or most pronounced of the disease. In general, it has been estimated that chordoma comprises one in every thousand admissions for malignant tumors.

Barnes and Owen,[1] review a series of 150 cases gathered by Mabrey. The approximate ratio of occurrence in various sites: cranial, five; vertibral, one and a half; and sacrococcygeal, nine. The tumors may appear at any age or in either sex. The highest incidence of sacrococcygeal chordomas is in the sixth decade in the male, and fifth decade in the female.

There is some difference in opinion regarding the importance of trauma as an etiological factor. This contention is supported by the fact that the tumor is more common in the male. Furthermore, investigators have shown that traumatization of the intervertebral discs in rabbits produces herniation of the nucleus polyposus resulting in proliferative changes in the chordal

rests which has the histologic appearance of chordoma. In addition, the history of injury is usually elicited.

In Mabrey's review the recognition of these tumors is made chiefly upon roentgenographic findings such as vacuolization and thickening of bony trabeculae and usually flattening of pelvic inlet. Chordoma must be differentiated from Paget's Disease, and from Osteitis fibrosis systica. Grossly the tumor is soft or cheesy in consistency, is gray to reddish in color with jelly-like cysts and occasional fibrous bands croscopically. These are characteristic epithelial-like vacuolated cells with centrally placed nuclei seen within an irregular, nucoid matrix. Tuberculosis, chondroma, chondrosarcoma, benign giant-cell tumors, dermoid tumors and colloid carcinoma must be excluded. Symptomatically, the patients complain of urinary disorders (dysuria, difficulty, or incontinence), pain in the perineum or buttock, radiating along the sciatic nerves, constipation or loss of rectal control, occult fecal blood, and a mass palpable externally or rectally. It has been shown that a low assay of urinary prolan may be found in these cases, and, when metastases (variously estimated between twenty-five, and, sixty per cent) or progression of the local lesion occur, this prolan is greatly increased.

Most investigators, including Mabrey, Barnes and Owen Coley,[2] and Bruce and Mekie[4] all feel that radical excision should be carried out whenever possible. Although such a procedure affords the best chance for cure the inaccessibility of sacral chordomas rarely permit such a radical treatment.

Most authorities agree that irradiation combined with excision is justified, although irradiation, alone, is only palliative in relieving pain and is usually without effect in reducing the tumor size. Recurrence after excision is generally to be expected.

One or two instances have been reported in the foreign literature of six-year "cures" from irradiation therapy. However, Nach and Daskey report the progress of one patient who merely had a suprapubic cystostomy performed accompanied by a disappearance of pain at the end of six years. They point out that if irradiation therapy had been instituted such therapy would have been accredited the good result.

While Young and Coley report successful radical extirpations without recurrences for one or two years, these cases are not really followed for a long enough period. In general, most authors agree that the prognosis is extremely poor.

Report of a Case

B. G., a seventy-year-old white man, consulted me in summer of 1939 complaining of inability to void. He had a transurethral resection of prostate in 1937, in the East, that apparently, afforded him some temporary relief but now had a return of his former symptoms. After urologic investigation I advised a radical prostatectomy but was unable to convince the patient and at his insistence I removed additional tissue by resection. The convalescence was marked by right epididymitis (although the vasae were supposedly ligated in 1937) and phlebitis. As he did not void satisfactorily and had a persistent pyuria I convinced him that radical prostatectomy was the correct solution and in September, 1937, I enucleated the gland suprapubically and he made a prompt convalescence and voided naturally.

Four months later, however, the patient complained of some difficulty in voiding and of pains in the rectum and penis. Examination revealed about twelve ounces of clear residual urine. During the ensuing eighteen months the voiding was more satisfactory and the residual urine disappeared. Yet a progressively distressing loss of voluntary rectal sphincter control occurred, and, finally, in June, 1941, the patient's urine passed involuntarily when he was on his feet. At this time the patient also complained of pain in the buttocks. Reexamination showed a large soft tumor in the left gluteal area and a smaller one in the mid-line. The laboratory findings were essentially normal. The roentgenographic study of the lower spine was of little value.

On July 21, 1941, exploration of the tumor mass was carried out and a lesion about the size of an orange was dissected free from its intimate attachment to the sacrum. A considerable defect was left in the latter and some portions of the tumor were unattainable.

The pathologic diagnosis of the lesion was chordoma although several areas microscopically suggested chondrosarcoma.

Recovery was uneventful. A course of deep x-ray therapy was then administered. However, in December, 1941, rectal palpation revealed an extension of the tumor.

The patient is able to be up and about his home. He empties the bladder fairly well but constipation has given him considerable trouble. During the past year the tumor has recurred but would soften and drain without incision. His appetite is good and general condition, fair.

I wish to thank Dr. Howard J. Hammer and Dr. Donald J. Jaffar for assistance in reviewing the literature.

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EDITORIAL

MEDICAL EVOLUTION

■ WE asked, "Have we a program?"

Medicine has been yearning toward better things since the dawn of history. Hippocrates required that his disciples teach their successors, and bound them to make new facts and new methods available to their confreres. Thus medicine became a profession. During the centuries a code of living (Ethics) has developed which has the respect of all right-minded persons. Reformers in every age, and especially our own, have charged that, because of this code, we are practicing medicine in the same antiquated way of our forefathers. These agitators have seized upon medical ethics, not knowing what these moral teachings are, only that they offer a chance for sabotage.

The profession has engineered its own evolution from within. It has adopted and developed methods of proven worth and benefit, and has rejected those not good. It has even aided in the socializing of medicine when such methods seemed the best way.

Years ago the Michigan State Medical Society secured the establishment of the Michigan Department of Health. The profession has been instrumental in the establishment of many state hospitals for the care of numerous types of people and conditions which have been demonstrated to be best handled as state charges. As a result small pox, diphtheria, typhoid fever have almost vanished as a cause of death. In two generations the life span of the American people has been nearly doubled.

Now bureaucracy proposes to take over. If medicine, unaided, can do what it has, why not make this service immediately available and free to all say the bureaucrats? Their schemes have been followed in certain socialistic countries, and others not entirely socialist, and the results have not been altogether good.

Bismarck gained control of Germany by giving free medical and hospital care of a sort. Britain recently proposed but has not adopted the Beveridge Plan. American enthusiasts have been agitating for a seizure of medicine for over a decade and a half. First came the report of the Committee on the costs of Medical Care, the first Wagner Bill, many minor bills, the Delano Report, the Supreme Court decision, the maternity-infant care project, and the present Wagner-Muray-Dingell Bills, all based upon a beautiful preamble to which there can be no objection.

MEDICAL EDUCATION

■ SOME months ago we questioned whether the proposal to telescope the Medical Education program would supply adequately trained Doctors of Medicine. A year has passed, and matters may now be reviewed. Soviet Russia has tried the telescoped course and found they could not train physicians properly in less than the normal time. They have abandoned the plan. Our own educators are now questioning this accelerated program, and are fearful that after the war a flood of inadequately trained men will be thrown back to the colleges for additional courses designed to fill out those that were shortened, and to supplement restricted medical internships. These men will have had one or several years of practice of a restricted variety, largely traumatic or emergency, and will need work to prepare them for a type of practice they will never have had.

This will occur at a time when our medical educational institutions are overcrowded with students and are understaffed with instructors. The college administrators are really concerned over the chaos that will ensue. So much has war and a degree of regimentation of the educational system done. What would be the condition under full bureaucratic control of the profession "from the cradle to the grave?"

It is time for our military leaders to recognize that their plan while designed to supply Medical Personnel for the war is actually disrupting the orderly progress of education and supply of adequately trained doctors for the postwar period. Why not adopt a more far-reaching program, being wise enough to plan for the whole nation? The telescoped courses cannot have much effect

(Continued on Page 236)

No Need for Compulsion Here

The annual County Secretaries' Conference and School of Information was held in Detroit on January 30, 1944. This will be known as one of the outstanding meetings of the year. I am sure that each and every member of the Society and the officers and members of the Woman's Auxiliary who were present gained much valuable information. Considerable attention was given to the Wagner-Murray-Dingell Bill by a number of outstanding speakers, and all agreed with those who characterized it as "fantastic in scope, idealistic in objective and extremely expensive in its economic aspect."

A short time ago, I received a letter from a doctor who is also an industrialist in which he states, "Recently I have had considerable conversation with a very well informed official of the CIO. He has read the Wagner-Murray-Dingel Bill through several times and is of the opinion that the medical profession would get farther by proposing a substitute bill correcting the evils of the former, rather than merely condemning it."

I believe we are all in accord with the idea that the people want some type of security for themselves and their families in all health fields. They do not wish to be regimented into a federal health program, but as honest, hardworking American citizens, they prefer to accept some plan of voluntary health insurance; to furnish this is the opportunity of the medical profession.

Recently, an editorial in one of Michigan's leading newspapers stated: "The American people feel there is something wrong with the medical profession. If the disciples of Hippocrates do not find a cure for the ailment, then less informed politicians with a knowledge of public sentiment will capitalize the grievances for the purpose of getting votes, and we will have State Medicine with all the waste, extravagance, inefficiency and the attendant horror of bureaucracy."

In Michigan, we doctors of medicine have a plan. Michigan Medical Service is meeting the needs of over 600,000 people in this state. If the medical profession will work together, first, for the extension to every interested person of the surgical care plan already offered by Michigan Medical Service, and, secondly, for broadening the program to provide pre-payment financing of other medical services in line with public demand, then, instead of one out of every nine residents in Michigan receiving the great benefits of Michigan Medical Service, our voluntary medical care plan will be available to a much larger number of our citizens and there will be no need for compulsory Federalized Medicine in Michigan.

C. R. Keyport

President, Michigan State Medical Society.

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President's



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on the number of doctors to graduate during the war, other than those who started early enough to have had their premedical courses. Why not plan now to serve the whole people, and incidentally better serve the armed forces?

OFFICIAL APPOINTEES

■ The Council at the mid-winter meeting in Detroit in January appointed the four officers who are Council Appointees. For Treasurer,



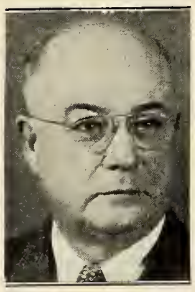
W. A. Hyland, M.D.



L. F. Foster, M.D.



W. J. Burns, LL.B.



Wilfrid Haughey, M.D.

William A. Hyland, M.D., of Grand Rapids who has served for many years; for Secretary, L. Fernald Foster, M.D., of Bay City who has been a tremendously active secretary and has been on call at all times for secretarial services and Public Relations officer; for Executive Secretary, William J. Burns, LL.B. Mr. Burns has been a great secretary, efficient, and always foreseeing calls that will be made upon him for time and assistance; for Editor, Wilfrid Haughey, M.D.

HAVE WE A PROGRAM?

■ TEN years ago our Michigan State Medical Society, after five years of study and the expenditure of over twenty thousand dollars, made a report on the distribution of costs of medical care in Michigan, with a proposal of a method of prepaid medical services. That was not adopted.

As the great depression gained upon us, our Society made another proposal aimed at furnishing medical services to our people through the use of the insurance principle; the profession planned to do it under private direction rather than by governmental and bureaucratic domination. To compete with governmental regimentation we must offer our people better services in a more acceptable form.

In 1939 the Medical Profession sponsored and fought through the Legislature two bills to permit the creation of group medical care and group hospitalization corporations. Michigan Medical Service was the answer and many of our members thought (and still do), that it can and will fill any gap. Michigan Medical Service was an evolutionary adventure into an absolutely new field. It was and is a great social experiment. Granted it made mistakes, it was and is ever ready and anxious to find and correct them. It appears that its troubles have about passed. One in nine Michigan citizens are subscribers to Michigan Medical Service, and in 1943, 3,289 different doctors of medicine were paid for 58,466 services to these subscribers. The bookkeeping deficit of 1942 is almost entirely wiped out and Michigan Medical Service will be in the black before half of 1944 goes by.

Some doctors believe Michigan Medical Service, if it could have the wholehearted support of all our members, might be in large part the answer to the Wagner-Murray-Dingell Bills and similar movements for the regimentation of medicine.

Public education in the problems of good health and adequate distribution of medical care is another part of our evolving program. Some steps have been taken along this line. The Michigan Health Council has been established. Studies are being made, certain groups have become sort of information centers, discussions of medico-sociologic problems have been undertaken by non-medical interests. More must be done.

We believe the way is being pointed for us by our own medical leaders in Michigan. We should all endeavor to help, not "sit by the side of the road and watch the world go by."

Michigan Doctors of Medicine in Military Service

Scattered throughout the world, laboring and fighting with America's aviators, marines, sailors and soldiers, are 1,763 Michigan Doctors of Medicine.

Michigan Medicine is proud of its physicians in uniform and their great contribution to the war effort.

Their sacrifices—even to laying down their lives, as have eight of our Michigan Doctors of Medicine—are a dramatic personification of medical history repeating itself.

We salute these men and glory in their achievements for Democracy. Their work and heroism is ensuring for us a continuation of the American way of life.

C. R. KEYPORT, M.D.
President, MSMS.



God Bless and Protect Them

Allegan

Beckett, M. B.	Major
Brown, L. E.	Capt.
Dolfin, W. M.	

Alpena-Alcona-Presque Isle

Foley, Arthur L.	Lt.
Kessler, Harold	Capt.
Martinson, Donald	Lt. (sg)
Nesbit, W. E.	Capt.
Ramsey, J. A.	Capt.
Rutledge, S. H.	Lt.
Trudeau, John	Capt.
Wienczewski, T. W.	Capt.

Barry

Altland, J. K.	Lt. Comdr. USN
Finnie, R. G.	Capt. AUS
Fisher, Gordon F.	Capt. AUS
McIntyre, K. S.	Lt. Comdr. USN
Prosper, G. Barnard	Capt. AUS

Bay-Arenac-Iosco-Gladwin

Asline, J. N.	Capt.
Burton, Horace	Capt.
Connelly, C. J.	Lt.
Dardas, Michael J.	Capt.
DeWaele, Paul	Lt.
Gronemeyer, W. H.	Capt.
Hagelshaw, G. L.	Lt. Col.
Hall, Robert F.	Capt.
Horowitz, S. Franklin ,	Capt.
Husted, F. Pitkin	Major
Jacoby, A. H.	Capt.
Knobloch, H. T.	Capt.
Lane, Milton	Lt.
Lerner, David	Lt.
McDonnell, W. R.	Lt.
McPhail, Joseph	Lt.(sg) USN
Medvesky, M. J.	Capt.
Miller, E. C.	Capt.
Moore, Neal R.	Capt.
Mosier, D. J.	Capt.
Pearson, S. M.	Capt.
Reutter, C. W.	Major
Riley, R. B.	Lt.
Shafer, H. C.	Capt.
Tarter, C. S.	Lt. Col.
Timreck, H. A.	Lt.
Woodbourne, H. L.	Capt.

Berrien

Bartlett, Walter M.	Lt. Col.
Brown, R. J.	Lt. Comdr. USN
Crowell, Richard C.	Lt. (sg) USN
Cutter, C. A.	AUS

★Died in Military Service.

Ellet, Wm. C.	Comdr. USN
Hershey, J. N.	AUS
Keppen, Ford	AUS
King, Frank, Jr.	Capt. AUS
Lane, Sidney	Lt. AUS
Lava, John B.	Capt.
Reagan, Robert	Lt. Comdr. USN
Rice, Franklin	AUS
Ruth, J. G.	Capt.
Sonneman, C. O.	Lt. AUS
Sowers, Bouton	Lt. Comdr. USN
Strayer, J. C.	Lt.
Woodford, Hackley	Lt. AUS

Branch

Chipman, E. M.	Capt.
Fraser, R. J.	Capt.
Joerin, Wm.	Lt.
Meier, H. J.	Capt.
Olmstead, Kenneth L.	Capt.
Scovill, H. A.	Capt.
Smith, L. L.	Capt.
Weidner, H. R.	Lt. Comdr. USN

Calhoun

Alpiner, Sam	Lt.
Amos, Norman H.	Lt. Comdr. USN
Becker, H. F.	Lt. Col.
Bonifer, Philip P.	Lt. (sg) USN
Brainard, C. W.	Lt. Comdr USN
Braham, W. G.	Lt.
Campbell, R. J.	Lt.(sg) USN
Capron, Manley J.	Capt. USN
Chynoweth, W. R.	Major
Clark, Eugene	Lt.
Curless, Grant R.	Capt.
Curry, Robert K.	Lt.
Dodge, W. M., Jr.	Major
Fallis, R. E.	Lt.
Forsythe, James	Lt.
Graubner, F. L.	Lt.
★Hale, C. E.	Capt.
Hansen, Harvey C.	Capt.
Hamilton, Lawrence E.	
Hoyt, A. W.	Lt.
Hubly, James W.	Capt.
Humphrey, Arthur	Lt. Comdr. USN
Jones, T. K.	Capt.
Keagle, Leland	Lt. (sg) USN
Kellher, George	Lt.
Kinde, M. R.	Major
Kingsley, Paul C.	Capt.
Lam, Francis L.	Lt.
Levy, Joseph	Capt.
Lowe, Kenneth	Lt. Comdr. USN
Lowe, Stanley	Capt.
Meister, F.	Major
Morrison, D. B.	Capt.
Mullenmeister, Hugh F.	Major
Norton, Richard	Major
Patterson, Adonis	Capt.
Peggs, Harold	Lt.
Prachar, Geo. A.	Lt.
Penzlar, Meyer	Lt.
Royer, Clark W.	Capt.
Simpson, Robert	Capt.
Slagle, George W.	Lt.(sg) USN
Sleight, James D.	Capt.
Smith, T. C.	Can. Army Capt.
Stadle, W. H.	Lt. Comdr. USN
Stewart, C. J.	Lt.
★Shick, W. H.	Lt.
Taylor, Clarence B.	Capt.
Wakeman, Everal	Lt.
Watson, B. A.	Major
Zinn, Karl	Capt.

Cass

Clary, R. I.	Lt. (sg) USN
Rice, F. G.	Capt.

Chippewa-Mackinac

Birch, Wm. G.	Major
Blair, Herbert M.	Capt.
Gilfillan, E. O.	Lt.
Hakala, L. J.	USPH
Mertaugh, Wm. F.	Major
Wallen, L. J.	Capt.

Clinton

Hart, Dean W.	Lt. Comdr. USN
Richards, Frank D.	Capt.
Russell, S. R.	Major
Slagh, E. M.	
Wahl, George E.	Capt.

Delta

Brenner, E. J.	Capt.
Clausen, Claire H.	Capt.
Fyvie, James H.	Lt.
LeMire, Wm. A.	Lt.
McInerney, Thomas	Capt.

Dickinson-Iron

Gloss, Kenneth E.	Major
Haight, H. H.	Lt. Comdr. USMC
McEachron, Hugh D.	Capt.
Retallack, R. C.	Capt.

Eaton

Brown, B. P.	Capt.
Carothers, Daniel J.	Lt.
Goff, Sidney	Capt.
Huyck, Stanhope P.	Capt.
Imthun, Edgar	Capt.
E. Madison Paine, Jr.	Capt.
Van Ark, Bert.	Capt.

Genesee

Adams, Chester H. Major
Andrews, Nelson A. Capt.
Anthony, George E. Capt.
Backus, Glen R. Capt.
Branch, Hira E. Capt.
Baker, Henry K. Lt.
Bald, F. W. Lt. Comdr. USN
Bateman, Lawrence G. Lt.
Burnside, Howard Capt.
Bernstein, Eli. Lt.
Beyer, Damon P. Lt.
Bradley, Robert Capt.
Bradford, Ferd. Lt.
Bruce, Wm. W. Lt.
Colwell, Clifford W. Major
Conover, George V. Lt. Comdr. USN
Cox, T. Jefferson Lt.
Drewyer, Glenn E. Lt. (sg) USN
Eickhorst, Thomas L. Lt. (sg) USN
Farhat, Maynard Capt.
Flynn, Southard T. Major
Finkelstein, Theodore Lt.
Fuller, Harvey T. Capt.
Gelenger, Stephen M. Capt.
Gorne, Saul S. Lt.
Gray, Edwin F. Capt.
Gutow, Julius J. Lt.
Hague. Robert F.
Hiscock, Harold H. Lt. Comdr. USN
Hubbard, Wm. B. Major
Johnson, Frank D. Major
Kaleta, Edward Lt.
Kaufman, Lewis D. Lt.
Lambert, Leslie A. Capt.
Miller, Loren E. Lt.
McArthur, R. H.
Rieth, George Lt.
Rowe, John Lt. (sg) USN
Rundles, Walter Z. Major
Sandy, Kenneth R. Capt.
Sartori, Max Lt.
Scarvada, Chas. J. Major
Schiff, Benton A. Lt.
Smith, Maurice J. Lt.
Snyder, Chas. E. Capt.
Sorkin, Maurice S. Lt.
Sorkin, Samuel S. Capt.
Steinman, Floyd H. Major
Tofteland, Elmer H. Lt.
Van Gorder, George F. Capt.
Vary, Edwin P. Lt. Comdr. USN
Walcott, Carver G. Lt. (sg) USN
Ward, Ivan W. Lt.
White, Carl Lt. Comdr. USN
Willoughby, Gordon L. Capt.
Woughter, Harold Lt.

Gogebic

Gullickson, Miles Lt.
Pinkerton, H. A. Lt. Comdr. USN
★ Reid, J. D. Lt.

Grand Traverse-Leelanau-Benzie

Baumann, Milton C. Capt.
Brownson, Kneale M. Major
Green, Richard Capt.
Hamilton, Earl E. Capt.
Huene, Nevin Capt.
Knapp, Jos. L. Major
Lemen, Chas. E. Capt.
Lentz, R. J. Capt.
Trautmen, Frederick B. Capt.
Way, Lewis R. Major
Zielke, I. H. Capt.
Nickels, M. M. Lt. Comdr. USN

Gratiot-Isabella-Clare

Barstow, D. K. Capt.
Dale, Edward C. Capt.
Davis, L. L. Capt.
Graham, B. J. Lt. (sg) USN
Hammerberg, Kuno Capt.
Hersee, Wm. E. Lt.
Miller, S. W. Capt.
Oldham, E. S. Lt. (sg) USN
Rottschafer, J. L. Lt. (sg) USN
Slattery, F. G. Lt. (sg) USN
Wolfe, Kenneth P. Capt.
Wood, Cornelius B. Lt.

Hillsdale

Johnson, C. E. Major
Kinzel, R. W. Capt.
Mattson, H. F. Capt.
Sandor, A. A. Capt.
Sawyer, Walter W. Lt. (sg) USN
Strom, A. W. Lt. (sg) USN

★Died in Military Service.

Houghton-Baraga-Keweenaw

Acocks, J. R. Capt.
Aldrich, Leonard Lt. Comdr. USN
Kadin, Maurice USA
Kolb, F. E. USA
Pleune, R. E. Capt.
Roche, A. M. Capt.
Tinetti, Ernest F. Capt.

Ingham

Brown, F. M. Capt.
Burhans, Robert Lt. Comdr. USN
Clark, William E. Capt.
Clinton, George Lt.
Doyle, Charles R. Capt.
Drolett, Donald J. Capt.
Drolett, Lawrence A. Capt.
Fisher, D. W. Major
Gibson, Thomas E. Major
Goldner, Roy E. Capt.
Heald, Gordon H. Capt.
Harris, Herbert Major
Harrold, J. F. Capt.
Hendren, Owen Major
Higgins, Eaner P. Lt.
Himmelberger, R. J. Capt.
Hodges, Kenneth Lt. (sg) USN
Hughes, Harold A. Lt. (jg) USN
Johnson, K. H. Capt.
Kelly, Wm. H. Capt.
LeDuc, Don M. Lt. Comdr. USNR
Ley, Wilfred Lt.
McGillicuddy, O. B. Major
McGillicuddy, R. J. Capt.
Meade, Wm. H. Capt.
Mercer, Walter E. Capt.
Molnar, Stephen K. Lt.
Morrow, R. J. Capt.
Potter, Earl Lt. (jg) USN
Richards, F. D. Capt.
Richards, R. Capt.
Robson, E. J. Lt. Comdr. USN
Rozan, M. M. Lt. Comdr. USN
Sander, John F. Lt. Comdr. USN
Silverman, Irving E. Lt.
Spencer, Perry Lt. (sg) USN
Stiles, Frank Lt. Comdr. USN
★ Sullivan, Ralph Lt.
Swartz, Frederick C. Major
Tamblyn, F. W. Lt. Comdr. USN
Thomas, Lucius G. Lt. Col.
Toothaker, Kenneth Lt. (sg) USN
Vander Zalm, T. P. Lt. Col.
Webb, Roy O. Capt.
Wellman, John M. Major

Ionia-Montcalm

Benison, A. L. Missing
Dunkin, Lloyd S. Major
Hansen, Carl M. Capt.
Kling, V. F. Lt.
Marston, Leo L. Lt.
Mintz, Morris J. Capt.
Seidel, Karl Lt.
Slagh, Milton E. Capt.
Van Loo, J. Capt.

Jackson

Ahronheim, J. H. Capt.
Appel, Saul Lt.
Bartholic, Francis W. Capt.
Cawley, Edward P. Capt.
Crowley, Edward D. Lt. Comdr. USN
Edmonds, John M. Capt.
Finton, Max Lt. (jg) USN
Finton, Walter F. Capt.
Gordon, Donald L. Lt. (jg) USN
Greenbaum, Harry Capt.
Hanna, Roger J. Major
Holst, John B. Capt.
LaVictoire, J. N. Lt. (sg) USN
Lake, Edward C. Capt.
Lenz, Chas. R. Lt.
Ludwick, John E. Lt. Comdr. USN
McLauthlin, Herbert B. Lt.
Meade, Robert Lt.
Miller, Jack L. Capt.
Murphy, Bernard M. Major
Otis, Grant L. Capt.
Ottoman, Richard Lt.
Scott, John A. Capt.
Seybold, Edward G. Capt.
Sirhal, Alfred M. Lt.
Southwick, W. A. Capt.
Sugar, Sam Capt.
Susskind, Myron V. Capt.
Tate, Cecil E. Lt.
Van Wagnen, Frederick I. Capt.
Vivirski, Edward E. Capt.
Walder, Harold Lt.
Wickham, Woodward A. Lt. (sg) USN
Oleksy, Stanley P. Lt.

Kalamazoo

Aach, Hugo Major
Andrews, Sherman E. Major
Bennett, Keith Major
Borgman, Wallace Capt.
Crawford, Kenneth Capt.
Dowd, Bernard Capt.
Doyle, F. M. Capt.
Fopeano, John Major
Fuller, Paul M. Major
Gilding, Joseph P. Capt.
Gray, Arthur S.
Hodgman, Albert B. Capt.
Holder, Chas. Capt.
Irwin, Wm. D. Capt.
Iseman, Joseph W. Major
Jackson, Howard Lt.
Kavanaugh, Wm. J. Capt.
Klerk, Wm. J. Lt.
Koestner, Paul A. Capt.
Kuhs, Milton Y. Lt.
MacGregor, John R. Capt.
Machin, Harold A. Capt.
Malone, James C. Capt.
McIntyre, Chas. H. Lt.
Marshall, Don Major
Moe, Carl Rex Lt.
Nell, Edward R. Lt.
Okun, Milton Capt.
Osborne, Chas. E. Lt.
Patmos, Martin Major
Peelen, J. William Capt.
Peelen, Matthew Major
Rigterink, Gerald Capt.
Ryan, Frederick Lt.
Schrier, Clarence M. Capt.
Schrier, Paul G. Lt. Comdr. USN
Schrier, Thomas Capt.
Scott, W. A. Major
Shaw, Geo. D. Capt.
Shook, Ralph Capt.
Siemsen, Wm. J. Major
Sofen, M. B. Capt.
Southworth, Maynard Lt.
TenHouten, Chas. Major
VerHage, Martin D. Lt.
Volderauer, John Capt.
Wagenaar, E. H. Major

Kent

Adams, F. A. Lt. Comdr. USN
Aitken, George T. Capt.
Alfenito, Felix S. Capt.
Balyeat, Gordon W. Lt.
Batts, Martin Capt.
Beaton, James H. Lt.
Beeman, Carl B. Capt.
Beets, W. Clarence Major
Bell, Charles M. Lt.
Bettison, Wm. L. Major
Boelkins, Richard C. Capt.
Boet, John Major
Brace, Fred Capt.
Brink, Russell Lt.
Buesing, O. R. Lt.
Carpenter, L. C. Capt.
Chadwick, W. L. Major
Collisi, Harrison S. Lt. Col.
Colvin, W. G. Capt.
Cosgrove, Wm. J. Capt.
Crane, Harold D. Lt. Comdr. USN
Damstra, H. J. Capt.
Davis, David B. Major
DeBoer, Clarence Lt.
DeBoer, Guy Wm. Capt.
DeVel, Leon Major
Dick, Mark W. Capt.
Dickstein, Bernard Capt.
Eaton, Robert M. Capt.
Failing, John F. Capt.
Farber, Charles E. Capt.
Fellows, Kenneth E. Capt.
Ferguson, James Capt.
Ferrand, Louis Capt.
Fitts, Ralph L. Capt.
Flynn, J. Donald Lt. USN
Frantz, Charles Lt. Col.
Freyling, Robert Lt. USN
Griffith, Lucien S. Major
Haeck, William Capt.
Hill, A. M. Major
Hilt, Lawrence Comdr. USN
Holdsworth, M. J. Capt.
Hollander, Stephan Capt.

Hoogerhyde, Jack Lt. Comdr. USN
Ingersoll, C. F. Major
Jameson, Fred M. Capt.
Kelly, Robert E. Lt. Comdr. USN
Klaus, C. D. Lt. USN
Kniskern, P. W. Capt.
Koontz, E. R. Capt.
Lentini, Joseph R. Capt.
McKenna, J. L. Capt.
MacDonald, Allen Lt.
Marrin, M. M. Lt. Col.
Miller, J. Duane Lt. Comdr. USN
Mitchell, H. C. Major
Moleski, Leo Capt.
Mouw, Richard Lt.
Murphy, M. J. Capt.
Nelson, A. R. Major
Payne, C. Allen Capt.
Pott, A. L. Capt.
Ralph, L. Paul Lt. Comdr. USN
Rogalski, Floyd Lt.
Roth, Emil M. Lt.
Schuitema, Donald Capt.
Sculley, Ray E. Capt.
Shellman, Millard W. Lt.
Sluyter, S. L. Lt.
Sluyter, J. S.
Steffensen, W. H. Capt.
Stover, Virgil E. Capt.
Swenson, H. C. Lt.
Tesseine, A. J. Capt.
Vander Meer, Ray Lt.
Van Solkema, Andrew Capt.
Van Solkema, Arthur Capt.
Van't Hof, Albert Lt.
Warmenhoven, Simon Lt. Col.
Webber, Jerome Lt.
Whalen, John Lt. Comdr.
Woodburne, A. R. Lt. Col.
Wurz, John Major
Yared, Jerome Lt.

Lapeer

Dorland, Clarke Capt.
Jackson, C. C. Capt.
McBride, J. R. Capt.

Lenawee

Beebe, I. J. Major
Campbell, C. A. Capt.
Claxton, W. T. Capt.
Hall, George C. Major
Hammel, H. H. Capt.
Helzerman, Ralph Capt.
Hinshaw, W. V. Capt.
Iler, H. D. Capt.
McCue, F. J., Jr. Lt.
McGarvey, M. R. Capt.
Miller, Perry Lynford Major
Pasternacki, Arthur Capt.
Patmos, Bernard Capt.
Rawson, A. P. Capt.
Rogers, John D. Capt.
Wynn, George H. Capt.

Livingston

Cameron, D. A. Capt.
Hayner, R. A. Capt.
Hill, Harold C. Lt. (sg)
Leslie, G. L. Major
Stephens, D. C. Lt. Comdr.

Luce

Lance, Paul E. Major
Surrell, Mathew A. Major
Swanson, George F. Lt. Col.

Macomb

Duerloo, H. W. Capt.
Dudzinski, Edmund J. Lt. (sg) USN
Huminski, T. S. Lt.
Klein, Wm. A. Lt.
Lance, Paul E. Major
Maguire, Andrew J. Lt. (sg) USN
Mattes, Max Lt.
Moran, F. T. Capt.
Mulligan, Phillip Capt.
Reichman, Joseph J. Capt.
Rivard, Chas. L. Capt.
Roth, Geo. E. Lt. (jg) USN
Rosenthal, S. A. Capt.
Rothman, Arthur M. Capt.
Salot, Russell F. Lt. Comdr. USN
Scher, J. N. Capt.
Stein, S. C. Lt.
Sylvan, Melvin M. Lt.
Wellard, Henry C. Major

★Died in Military Service.

Manistee

Hansen, Ernest C. Lt. Comdr. USN
Konopa, John F. Capt.
Ogilvie, Gordon D. Lt.

Marquette-Alger

Baron, B. C. Major
Bennett, Matthew Capt.
Bryce, James Capt.
Fennig, Foster Capt.
Hanelin, H. A. Lt.
Hornbogen, D. P. Lt. Comdr. USN
Janes, Grant Capt.
Lambert, Warren Capt.
Le Golvan, Paul Major
Nickolson, John Capt.
Niemi, Osmo I. Capt.
Schutz, W. J. Capt.

Mason

Commodo, Nicholas M. Capt.
Hoffman, Howard B. Capt.
Ostrander, Robert A. Capt.

Mecosta-Osceola-Lake

Ivkovich, Paul Lt.
Klein, J. Paul Lt.
Phillips, W. R. Capt.

Medical Society of North Central Counties

Lanting, Roelof Capt.
Leland, Sargent Lt.
McDowell, Douglas Lt.

Menominee

Heidenreich, John R. Major
Sethney, Walter Capt.

Midland

Meisel, Edward Lt.
VonHaitinger, Kalmon Capt.

Monroe

Barker, Vincent L. Comdr. USN
Bond, W. W. Capt.
Cohen, H. Herbert Lt.
Denman, Dean C. Lt. Comdr. USN
Flanders, J. P. Lt.
Goodman, Louis Capt.
Hunter, Marion A. Capt.
Lindquist, Paul Capt.
Long, Edgar C. Major
Penszotti, S. C. Capt.
Reisig, A. H. Capt.
Stolpestad, C. T. Capt.
Williams, Robt. J. Lt. Comdr. USN

Newaygo

Geerling, Lewis Lt.
Gordon, B. F. Lt.

Northern Michigan Medical Society

Conway, Wm. S. Capt.
Giffords, Mark Lt.
Miller, Samuel L. Major
Winter, Joseph A. Lt.
Lilga, Harris V. Capt.
Lentini, Nicholas Capt.
McCune, Wm. S. Lt.

Oakland

Abbott, Vernon C. Lt. Comdr. USN
Benning, C. H. USPHS
Boucher, Roman E. Lt.
Campbell, Mac D. Capt.
Caumartin, Hugh Lt.
Christie, J. W. Capt.
Cooper, Robert J. Lt. Comdr. USN
Dobski, E. J. Capt.
Domeier, L. H. Lt.
Faulconer, Albert Lt.
Flick, Earl J. Lt.
Foust, E. W. Capt.
Francis, Donald Lt.
Furlong, Harold Lt. Col.
Gately, C. R. Capt.
Gill, Matthew J. Lt.
Hammer, Carl W. Lt.
Hammonds, Everett E. Capt.
Hassberger, J. B. Lt. Comdr. USNR
Hoyt, D. F. Lt. Comdr. USNR
Hubert, John R. Capt.
Lass, Edward H. Lt.
Little, J. W. USPHS
McEvoy, F. J. Lt. Comdr. USN
Markley, John M. Lt.
Mason, Robert J. Lt. Comdr. USN
Morrell, Wm. B. Lt.
Moosman, B. A. Capt.
Needles, Francis H. Lt. USNR
Nosanchuck, Joseph Lt.
Olmacher, E. P. Major
Olsen, Richard E. Lt.
★Osgood, W. S. Capt.
Pauli, T. J. Major
Pelletier, Chas. J. Lt.
Porritt, Ross Major
Ports, Preston W. Lt.
Russell, Vincent P. Lt. USN
Schlecte, Erwin Carl Lt.
Schoenfeld, John B. Capt.
Shadley, M. L. Capt.
Smith, Carlton A. Lt.
Smith, Donald S. Lt. USN
Spencer, Floyd E. Capt.
Spohn, Earl W. Capt.
Stanley, Arthur Capt.
Stanley, Wm. F. Lt.
Stolpman, A. K. Lt. USN
★Terry, Stewart Lt. USN
Wagley, P. V. Major
Watson, Thomas Lt. USN
Williams, J. B. Lt.
Wentz, Arthur E. Lt. USN

Oceana

Flint, Charles Major
Lemke, Walter Capt.
Robinson, W. Gordon Lt.

Ontonagan

Rubinfeld, S. H. Capt.

Ottawa

Clark, Nelson
Cook, Carl
DeYoung, Fred
Hager, Ralph
Harms, H. P. Lt. Comdr. USN
Rypkema, Wm. Lt.
Timmerman, E. C.
Wells, Kenneth

Saginaw

Bishop, Mortimer H. Lt. Comdr.
Butler, Milton G. Capt.
Chisena, Peter R. Lt.
Cortopassi, Vitalis E. Capt.
Cory, Charles W. Capt.
Curts, James H. Lt. (sg) USN
Frantz, Charles H. Major
Gage, David P. Capt.
Gerber, Herbert Lt.
Grigg, Arthur P. Lt. USN
Hand, Eugene Lt. (sg) USN
Hester, E. G. Lt.
Immerman, Harold Capt.
James, John W. Capt.
Kerr, Wm. Lt. (jg) USN
Lurie, Robert Major
Luger, Fred Capt.
MacAlpine, O. D. Capt.
MacMeekin, James W. Lt. (sg) USN
Mauer, John A. Capt.
Morgrette, L. J. Capt.
Mudd, Richard Lt. Col.
Murray, Charles R. Lt. USN
Phillips, Homer A. Lt.
Potvin, Clifford Capt.
Richards, Ned W. Capt.
Richter, Harry J. Lt. (sg) USN
Ryan, Richard S. Lt. Comdr.
Sargent, Donald V. Lt.
Schneider, A. Lt.
Schultz, Frank Lt.
Sheldon, Suel A. Comdr. USN
Skrowronski, Casimer A. Lt.
Slack, Walter K. Lt. Comdr. USN
Stander, Carl A. Capt.
Stewart, George Wm. Capt.
Thompson, Arthur B. Lt.
Tiedke, Gunther E. Lt. Comdr. USN
Wallace, Herbert C. Major
Yntema, Stuart Major

Sanilac

Koch, Donald A. Lt.
Norgaard, Hal V. Capt.

Shiawassee

Backe, John C. Capt.
Brandel, John M. Capt.
Brown, Richard J. Lt.
Buzzard, Walter D. Lt.
Janci, Julius S. Lt.
Kaufman, H. J. Lt.
Linden, V. E. Lt.
McKnight, Edwin R. Capt.
Shepherd, Walter F. Capt.
Slagh, E. M. Lt.
Wilcox, C. M. Capt.

St. Clair

Bigger, Robert J. Lt (sg) USN
Clyne, Benjamin C. Capt.
Kirker, F. O. Capt.
LeGalley, Kenneth B. Capt.
Licker, Rueben R. Lt.
Ludwig, Frederick A. Lt. (sg) USN
Witter, G. L. Major

St. Joseph

Berg, L. A. Lt. USN
Buell, M. F. USPHS
Fiegel, S. Albert Lt. USN
Hoekman, Aben Capt.
Holm, A. G. Capt.
Raisch, Frederick J. Lt.
Rice, John Wesley Lt. USN
Shaw, Geo. D. Capt.
Sheldon, John Lt.
Zimont, R. D. Lt.

Tuscola

Fisher, R. D. Lt.
Gugino, Frank J. Lt.
Hoffman, T. E. Lt. Comdr. USN
Vail, H. E. Capt.

Van Buren

Diephuis, Bert Capt.
Gano, Avison Capt.
Giddings, Ralph R. Capt.
Hall, Edward J. Capt.
Hasty, Willis Arthur Capt.
Iseman, J. W. Capt.
Terwilliger, Edwin Major
TenHouten, Charles Capt.

Washtenaw

Agate, George H.
Armstrong, Richard C. Lt.
Avery, Noyes L.
Baer, Louis S. Lt.
Barnes, Allan C. Capt.
Bauer, Gerhard H.
Block, Malcolm Lt.
Browns, Hershall L.
Bryan, John A.
Bullington, Bert M.
Bulmer, Dan J. Major
Buscaglia, J. C. Lt.
Butler, Wm.
Byrn, Robert W. Capt.
Cochran, Wm. L. Lt.
Conger, Kyril B. Capt.
Cook, Eugene L. Lt.
Cooper, Ralph R. Capt.
Courville, Chas. G. Capt.
Crabtree, Peter Capt.
Craig, James B. Capt.
Craig, Wm. R. Lt.
Davis, Fenimore E. Major
Day, A. Jackson Lt.
Denham. Robert
Diamond, Barnard L.
Dimitroff, Sim
Douglas, James B. Lt.
Dowman, Chas. E.
Due, Floyd O. Lt.
Duff, Ivan F.
Farrior, J. Brown Capt.
Ferber, Leon
Fink, Myron Lt.
Fitzgerald, Thomas D. Capt.
French, H. A.
Frohlich, Moses M. Major
Fuller, Wm. C. Lt.
Gardiner, Sprague Capt.
Gass, H. Harvey Lt.
Goldhamer, S. M. Major
Greene, Mervin E. Lt.
Gustafson, Jack R. Lt.
Hagerman, Geo. W. Capt.
Hammond, George Major
Harris, B. M. Lt. Comdr. USN
High, Howard C., Jr. Lt.
Hirschfeld, Alexander Lt.
Houston, Wm.

Washtenaw (Continued)

Howes, Homer A. Capt.
Hunt, H. Homer
Jackson, Raymond S. Lt.
Jackson, Richard G. Lt.
Jackson, Robert T. Lt.
Jay, Baird
Jennings, Hal. B. Lt.
Johnson, L. J. Lt. Comdr.
Joistead, Arthur H. Capt.
Jones, Ellis Lt.
Jordan, Paul H. Capt.
Kahn, Edgar A. Lt. Col.
Keller, Arthur P. Capt.
Kiehn, Clifford L. Capt.
Kimbrough, Robert C.
King, Walter
Lapides, Jack Lt.
Levin, Manuel
List, Martin L. Lt.
Little, Sam C. Lt.
Locklin, W. Kaye
Lowell, Vivion F. Capt.
Lusk, Harry A. Lt.
MacIntyre, Dugald S.
MacLean, Kenneth F. Lt.
Maddock, Walter G. Col.
Marks, Frederick
Marshall, John S. Lt.
Miller, Harold V. Capt.
Mills, Richard W. Lt.
Mollin, Edwin Lt.
Moore, Donald Floyd Lt.
Muehlig, G. Kenneth Capt.
Mueller, Robert J. Lt.
Mundt, Leslie
Musselman, Merle
Nunnemaker, John C. Capt.
Oliver, Richard Lt.
Palmer, A. A.
Pederson, Svend
Power, Frank H. Lt.
Quarton, Albert E.
Rague, Paul O. Capt.
Reiff, Wm. H. Lt.
Reynolds, Stephen Lt.
Rower, Peter
Runge, Paul W.
Russell, Stuart W. Lt.
Sachs, Allen E.
Salon, Dayton D. Capt.
Saunders, Allen Lt.
Schopp, Alvin
Scott, Robert Redvers
Scott, Wm. C. Lt.
Scurry, Maurice McL. Lt.
Sheldon, John M. Major
Singleton, Albert O. Lt.
Slaughter, John C.
Sludder, Gerald A.
Smith, Joseph G.
Snyder, Robert D. Capt.
Steffe, Ralph S. Lt.
Stevens, Harold Lt.
Stewart, Wayne H. Lt.
Strayer, John W. Lt.
Sweet, Robert B.
Teed, Wallace R. Lt. Comdr. USN
Thieme, E. Thurston Capt.
Thirlby, Richard L. Lt.
Thomson, Daniel C.
Thomson, John W.
Towsley, Harry A. Major
Uphold, Henry
Volk, William L.
Waldron, Alexander M.
Weeks, Wm. F. Lt.
Whitaker. Spires
Wile, Udo J. Col. USPHS
Wilkinson, Charles F.
Wilson, Claude D. Lt.
Windrow, Frank H. Capt.
Wright, Edwin M. Lt.

Wayne

Abruzzo, Anthony M. Capt.
Adelson, Sidney L. Capt.
Adler, Sidney Lt. (jg)
Agin, Lambert J. Lt.
Albert, Samuel
Aldrich, Napier USPHS
Ale, Thompson
Alexander, Martin M. Lt.
Alm, Bernard T. Lt. Col.
Alper, Louis Lt.
Altshuler, Samuel S. Major
Anderson, John Wm. Lt.
Anderson, Gordon H. Lt.
Anderson, R. F. Lt.
Anderson, Walter L. Capt.
Anderson, Walter T. Capt.
Andre, Harvey M. Lt.

Wayne (Continued)

Andrews, Raymond, Jr.
Angell, Howard H. Lt.
Arehart, Burke W. Lt.
Arminski, Thomas C.
Arms, A. V.
Armstrong, John Wm.
Ascher, Meyer S. Lt. (sg)
Ashley, L. Byron Lt. Col.
Askwig, Leroy C. Major
Asselin, Dean R. Lt.
Asselin, Regis F. Lt.
Atler, Leroy Capt.
August, Harry E. Major
Babcock, Kenneth B. Major
Bader, B. H. Capt.
Bagley, Harry E. Capt.
Bailey, Carl C. Capt.
Bailey, John H. U. S. Army
Bailey, Wm. J. Lt.
Baker, Wm. S., Jr. USN
Balberor, Harry Lt.
Barak, Lewis R.
Barenholtz, Benjamin
Barnett, Louis L. Capt.
Barr, Edward
Barron, James
Bates, Gaylord S. Lt. Comdr. USN
Bauer, L. E. Lt. Comdr. USN
Baumer, Moe Capt.
Bausch, Richard G.
Beam, A. Duane Lt.
Beck, Carl H.
Becker, Abraham Capt.
Beckwitt, Morris C. Capt.
Beer, John Lt.
Beer, Joseph Lt.
Beers, Morrison D. Lt.
Beeuwkes, L. E. Capt.
Beitman, Max Lt.
Belanger, Ernest Lt.
Belanger, Wm. Geo. Lt.
Belisle, John A.
Belknap, Warren F. Lt.
Bennett, Matthew C. Capt.
Benson, C. D. Lt. Comdr. USN
Benson, Davis A. Lt.
Benzing, Wm. M., Jr.
Beresh, Louis Capt.
Bergman, Theodore I. Capt.
Bergo, Howard L. Capt.
Berkow, Kenneth A. Capt.
Berlien, Ivan C. Capt.
Bermel, John USN
Berman, Sidney Lt. Comdr. USN
Bernstein, Samuel S. Capt.
Berry, Robt. E. L. Lt.
Besancon, J. H. Lt. Comdr. USN
Best, John Wm. Lt.
Bertucci, R. Joseph
Bicknell, Edgar A. Capt.
Bickenell, Frank B. Capt.
Biery, Martin Luther Capt.
Binkley, Edward L. US Army
Birch, John R. Capt.
Birndorf, Leonard Lt.
Black, Franklin R.
Blake, Henry S. US Army
Blain, James H. Capt.
Blashill, James B. Capt.
Blodgett, Wm. H. Capt.
Boccaccio, John Lt.
Boccia, James J.
Bohn, Stephen Lt. USN
Boileau, Thornton I. Lt.
Boles, A. E. Lt.
Bookstein, Abraham Lt.
Bott, Edmund Thomas
Bovill, E. G. Lt. Comdr. USN
Boyd, John C.
Bradford, Henry Lt.
Bradley, Geo. T.
Brancheau, L. T. Lt.
Braun, Lionel Capt.
Brines, O. A. Lt. Comdr. USN
Bringard, E. L. Capt.
Britton, Geo. T. Lt.
Bromme, Wm. Major
Brooks, Chas. W. Capt.
Brooks, Mason
Brooks, Nathan Lt.
Brough, Glenn Lt. Comdr. USN
Brown, Andrew G.
Brown, Carlton F. Capt.
Brown, John R. Lt. Comdr.
Brown, Marion G. Lt. USA
Brown, Robt. W. USA
Brownell, Paul G. Capt.
Bruer, Edwin Louis USA
Bryan, Donald I.
Bryce, John D. Lt. Comdr. USN
Buchner, Harold W. Capt.
Buell, Martin

Wayne (Continued)

Burgess, Woodrow W.
Burroughs, Rosswell G.
Burnstein, Perry P. Capt.
Bush, Glendon J. Capt.
Butler, Frank J. USA
Caldwell, J. Ewart Lt. Col.
Calkins, H. N. Capt.
Callaghan, T. T. Major
Campbell, Chas. A. USN
Campbell, Mac. D. Capt.
Campbell, Wm. J. Lt.
Caplan, Leslie Capt.
Caraway, James E. Capt.
Carnes, Harry E. Capt.
Carp. Joseph Capt.
Carron, Harold Lt.
Carstens, Henry R. Col.
Carstenson, Vincent H. Lt.
Carter, Harold G. Lt.
Cathcart, Edward Lt. Comdr. USN
Caumartin, Hugh
Caughey, Edgar H. Lt.
Cavell, Roscoe Lt. Col.
Chapnick, H. A. Capt.
Chason, Jacob L. USA
Chesluk, Herman M. Capt.
Childs, Geo. M. Capt.
Chittenden, Geo. E. Major
Christenson, Robt. C. USA
Chudnoff, Jack S.
Cigany, Zoltan B. Lt.
Clark, Benj. W. Lt. Comdr. USN
Clark, James Y.
Clarke, Niles A. Capt.
Clifford, John E. Capt.
Clifford, Robt. P. Lt.
Cohn, Daniel E. Capt.
Cole, Wyman, C. C. Lt. Col.
Collins, Arthur D. Capt.
Conn, Harold Lt.
Conn, Raymond W. Lt.
Conrad, C. D.
Conrad, Maynard M.
Cook, James A. Lt.
Cook, James C.
Cooley, John B. Lt.
Cooper, Benj. F.
Corrigan, Edmund USN
Coucke, Henry O. Capt.
Cowan, John S. Lt.
Cowley, Leonard L.
Crane, Thomas P.
Cretsinger, Francis Lt.
Crews, Thomas H.
Croll, Lee J. Capt.
Croll, Maurice Lt.
Cross, Kenneth R. Lt.
Croushore, James E. Major
Crowley, Robt. T. Capt.
Culp, Ormond Capt.
Culver, Dean T.
Cummings, Kenneth L.
Czeresko, Anthony R.
Dale, Mark
Daly, Byrne M. Lt.
Dana, Harold M. Major
Daughtry, Dewitt C.
Asst. Surg. USPHS
Davidson, Harry O. Capt.
Davies, Windsor S. Lt.
Davis, Geo. H. Lt. Comdr. USN
Davis, Linden Lee Major
Davis, Wm. H.
Day, J. Claude Lt. USN
Deering, Robt. James Capt.
Defever, Cyril R. Lt. Comdr.
DeCroat, Albert Major
Delbert, Stewart G. Capt.
Deming, Edward G. USA
Dennis, Melvin S. Lt.
Deresz, Alphonse R. USA
Derleth, Paul E. Lt.
Deutsch, Wm. L. Lt.
Day, Jack Lt.
Dickman, Harry M. Lt.
Dilihant, Jack Capt.
DiLoreto, Panfilio Camillo Lt.
Diskin, Herman Lt.
Dixon, Fred W. Lt.
Dixon, Ralph C. Lt.
Doerr, Louis E. Capt.
Dolega, Stanley F. Capt.
Domeier, Luverne H.
Donald, Douglas Major
Donovan, Richard S. Lt.
Doran, Joseph K.
Douglas, Clair L. Major
Douns, James T. USA
Drake, Ellet H. USPHS
Ducey, Edward F.
Duchesneau, Ferdinand Lt.
Dunlap, Gregg L. USA
Durham, Everett W. USA
Durocher, Normand E. Lt.
Durocher, Raymond
Dwyer, Francis Lt. Comdr. USN
Dziuba, John F. Lt.
Eades, Charles C. Capt.
Easley, John H. Capt.
Eder, Joseph R. Capt.
Edmundson, Robt. B. Lt.
Ellias, Elmer P.
Ellis, Calvin C.
Ellis, Seth W. Major
End, Jack A.
Engel, Earl H. Lt. Comdr. USN
Eno, Laurel S. Lt.
Ersfeld, Murray P. Lt.
Eschbach, Joseph W. Capt.
Evans, Wm. A. Capt.
Ewing, C. H. Capt.
Exum, Wm. A.
Falick, Mordecai L. Capt.
Fandrich, Theodore Lt.
Feigelman, Meyer J. Lt.
Feldkamp, Les E. Lt.
Feldman, Nathaniel L. Major
Feldman, Milton
Feldman, Paul P. Lt.
Feldstein, Martin Z. Capt.
Fenech, Harold B. Major
Fenton, Meryl M. Capt.
Ferguson, Franklin F. Major
Ferrara, Louis V. Lt.
Finch, Sinclair F.
Finlayson, Donald D. Lt. (jg) USN
Finton, Max A.
Fischer, Frederick J. Capt.
Fischer, Willard E.
Fisher, Geo. S. Lt.
Fitzgerald, E. W. Lt. Comdr. USN
Fitzgerald, James M. Capt.
Flaherty, N. W. Capt.
Flood, Richard E. Lt.
Flora, Wm. R. Lt. Comdr. USN
Florentz, Theodore R. Lt.
Ford, Sylvester Capt.
Forsythe, John R. Major
Foster, Alfred R.
Foster, E. Bruce Capt.
Fralik, Howard E. USA
Francis, Donald
Fraser, Harvey E. Capt.
Free, Harry W. Capt.
Freedland, Morris
Freedman, John Capt.
Fremont, J. Courtney
Lt. Comdr. USN
Fried, Bernard H. Lt.
Friedlander, Sidney Capt.
Frostic, Wm. D. Lt.
Fuller, Hugh M. Capt.
Gaba, Howard Lt.
Gabe, Sigmund Capt.
Gaines, Sidney
Gardner, Joe Harris Lt.
Gaston. Herbert B. Lt.
Geib, Wayne A. Capt.
Geise, Harold Lt.
Gill, John N.
Gilmore, John R. Lt.
Gingold, Samuel M. Lt.
Gingrich, Wayne A. Capt.
Ginsberg, Harold I. Lt.
Gitlin, Chas. Capt.
Gladman, Arthur E.
Glattauer, Alfred USA
Glickman, G. L. Capt.
Glodt, Herbert R.
Goder, Geo. A. Capt.
Goetz, Angus G. Lt. Comdr. USN
Goldberg, Arthur Lt.
Goldin, M. I. Lt.
Goldman, Aubrey Lt.
Goldman, Bernard J.
Goldman, Perry Lt.
Goldstone, Beris A.
Goley, Donald E. USPHS
Gollman, Maurice D. Capt.
Good, Wm. H., Jr. Capt.
Goodman, Louis
Goodman, Max USA
Goodrich, Benj. E. Lt. Comdr. USN
Gordon, Devitt L. Lt.
Gordon, Wm. H. Col.
★Gorelick, Harry S.
Gorelick, Martin J. Capt.
Goryl, Stephen B. Lt.
Goss, S. B. Lt.
Gourley, Eugene V. Major
Gradis, Howard H.
Grant, Gordon Lt. USN
Gray, Arthur S.
Green, Louis M. Lt.
Green, Sydney H. Lt.
Greenberg, Julius J. Lt.
Greenberg, Morris Z. Major
Greenwood, J. Harrison USN
Grimaldi, Gregory J. Lt. USN
Groscost, Arthur G.
Grossman, S. C. Capt.
Gutman, Emil Lt.
Gutow, B. R. Capt.
Gutterman, Meyer A. USA
Halper, Bernard
Hamburger, Albert C. Capt.
Hammer, Howard J. Capt.
Hammer, John M. Capt.
Hammer, Raymond Lt.
Hanelin, Joseph Lt.
Hankins, Chas. R. Lt.
Hanna, Carl Lt. Col.
Hanson, Curtis M. USA
Hanson, Frederick M. Lt.
Hargrave, Dudley W. USA
Harley, Garth W. USA
Harper, Jesse T. Major
Harrel, D. G. Capt.
Harris, Harold H. Lt. Comdr. USN
Hart, Chas. E. Lt.
Hart, John C. Lt.
Harryman, James E. USA
Hartzell, John B. Lt. Comdr.
Harvey, Edward R., Jr. USA
Hause, Glen E. Capt.
Hauser, Jerome I. Capt.
Hauser, M. J. USA
Hays, A. L.
Heavner, Lyle E. Lt.
Heideman, Louis E. Lt.
Hein, Richard J. Lt.
Henderson, A. B. Lt.
Henderson, Richard G.
Henderson, Wm. W. Lt.
Hendricks, Roger C.
Heneveld, Edward H.
Henig, Fred USPHS
Henry, Chas. M. Capt.
Henry, Joseph R.
Herbert, Walter N. Lt.
Herkimer, Daniel R.
Lt. Comdr. USN
Herschelmann, Roy F. Lt.
Herwick, John T. USA
Hewitt, Robt. S. Capt.
Hileman, Walter
Hill, John R. Lt.
Hillenbrand, Alfred E. Capt.
Hilsenbeck, John R. USA
Hodges, Jason USA
Hodgkinson, C. P. Capt.
Hoffman, Harry Y.
Hoffman, Henry A. Capt.
Holden, M. H.
Hollingsworth, Robt. S.
Holman, Herbert H. Capt.
Holstein, Arthur P. Lt.
Hooker, Donald H. Capt.
Hookey, John A. Capt.
Hoopes, Benj. F. Lt. Comdr. USN
Horan, Thomas N. Major
Horny, Hugo Lt.
Horwitz, John B. Capt.
Hotchkiss, Wm. S.
Howard, Merildeen W.
Hoyt, Arthur W. Lt.
Hubbard, Robt. D. USA
Huegli, W. A. Lt.
Huff, Ralph H. Lt.
Huffman, Elson R. Lt.
Hummel, Arthur Lt.
Hunt, Homer H. USA
Hyatt, Jarvis M. Capt.
Hyman, Samuel Lt.
Iacobell, Peter H. Lt.
Ihle, Lyman E. Capt.
Israel, Barney B. Capt.
Iverson, Preston C.
Ivkovich, Peter Lt.
Jackson. H. H., Jr. USN
Jacoby, Jack M. Lt. (jg) USN
Jaffe, J. L.
Jaffe, Louis Capt.
Janes, R. Capt.
Janton, Otto H. Lt. (jg) USN
Jasion, Lawrence J. Capt.
Jenkins, Elwood A. Lt.
Jennings, Robt. M. Lt.
Johnson, Clarence E.
Johnson, Franklin Lt.
Johnson, Richard E. Lt (jg) USN
Johnson, Tom D.
Johnston, Charles G.
Lt. Comdr. USN
Jones, Horace C. Lt. Comdr. USN
Jones, Wm. E.
Jordan, Prescott, Jr.
Joyce, G.

★Died in Military Service.

Wayne (Continued)

Joyce, Stanley J. Lt. Comdr. USN
Juliar, Benjamin Lt.
Kallman, Rueben R. Lt. Comdr. USN
Kanter, Herman Capt.
Kaplita, Walter A. Lt.
Kass, Arnold
Kauffman, Wm. Capt.
Kay, Harry H. Lt.
Kazdan, Louis L. Lt.
Kazdan, Morris A. Capt.
Keene, Clifford H. Capt.
★Kelley, Frank J.
Kelly, Alfred J. USA
Kelly, Wendell USPHS
Kendig, Tom Lt.
Kennedy, Donald J. Lt.
Kernick, Melvin O. Capt.
Kerr, Wm. B. USA
Kersker, Peter B. USPHS
Keyes, John W. Capt.
Kimball, David C. Lt. Comdr. USN
Kimberlin, Kenneth K. Lt.
King, Melbourne J. Lt.
Kingsley, Summer B.
Klein, Cyrus P. Lt.
Kitzmiller, John L.
Klinkowstein, Alex
Knaggs, Earl J. Lt.
Knapp, Byron S. Capt.
Knapp, Wm. D.
Knoch, Hubert S. Lt.
Kohn, Arthur M. Capt.
Kohn, Max Capt.
Kokowicz, Raymond J. Lt.
Koon, Wm. D. Lt.
Kosanovic, Frederick Lt.
Koss, Frank R. Capt.
Kossayda, Adam W. Lt.
Kovan, Dennis D. Capt.
Kove, Simon
Kozlinski, Anthony E. Lt. (sg) USN
Krass, E. W. Major
Kucmierz, Francis S. Lt.
Kuhn, A. Albert Lt.
Kuhn, Richard F. Lt.
Kuhn, Robt. USA
Kullman, Harold J. Lt. Comdr. USN
Kurcz, Joseph A. Capt.
LaBerge, James M. Capt.
LaCore, Ivan A. Capt.
Lammy, James V. Major
Lange, Wm. A. Capt.
Lansky, Mandell Lt.
Lapham, Fred Lt.
LaRue, Robert E. Lt.
Laub, Stanley V. Lt. Comdr. USN
Lauppe, Frederick A. Capt.
Lawton, Alfred H. USPHS
Lazar, Morton R. Lt.
Lazarski, K. M. USN
Leach, David Capt.
LeGallee, G. M. Lt. Comdr. USN
Lehman, Wm. L. Lt. (jg) USN
Leipsitz, L. S. Lt.
Leland, Soloman Lt.
Lemmon, Chas. E. Major
Lentine, James J. Lt.
Lepisto, Victor E.
Levigood, Floyd B. Capt.
Levant, Arthur B. Lt.
Levin, David M. Capt.
Levin, Michael M. Capt.
Levin, Samuel J. Lt. Comdr. USN
Levine, Edward E. Lt.
Lewis, J. Hugh Major
Lewis, Wilfrid John Capt.
Lichter, M. L. Lt.
Lipschutz, Louis S. Major
Lipton. Raymond F.
List, Harold E.
Livingston, Geo. D. Lt.
Lofstrom, James R. Major
Long, John J. Capt.
Longyear, Harold W. Lt.
Loomis, Frederick C.
Loranger, Guy L. Capt.
Lorber, Joseph H. Lt.
Lord, Herman M. Capt.
Lovas, Wm. S. Lt.
Lowenstine, Adolf W.
Lukas, John R.
Lum, T. K. Capt.
Lund, Anthony J.
Lynch, Chas. H.
Lynch, Vincent A.
Lynk, Stanley M. USA
McCadie, James H. USA
McCauley, Morris D. Lt.
McClure, Robert W. Capt.
McColl, Charles W. Capt.
McCullough, Francis E. Lt.
McCollum, E. B. Capt.
McDonald, Peter W. Capt.
McGarvah, Joseph A. Lt.
McGlaughlan, Nicholas D.
McGough, Joseph M. Capt.
McGraw, Arthur B. Lt. Comdr. USN
McGuire, Ivan A. USA
McIntyre, Wm. B. USN
McKean, G. T. Capt.
McKean, Richard M. Lt. Col.
McKenna, Chas. J. Capt.
McLean, Don W. Capt.
McNickle, Jerry H. USA
McQuiggan, Paul F. Capt.
McRae, James H. USA
Mabley, J. Donald Major
Mack, Harold C. Capt.
MacMillan, James M. Capt.
Maibauer, F. P. Capt.
Maire, Edward D. Capt.
Maire, Harold U. Capt.
Maison, Geo. L.
Mandiberg, Jack N. Lt.
Maples, Douglas E. Lt.
Maresh, E. R. Lt.
Marino, Chas. J.
Marion, Donald F. Capt.
Mark, Jerome Capt.
Marks, Ben Capt.
Markus, Ervin Capt.
Marshall, Millard R. Lt.
Martin, Peter A. Lt.
Martin, Richard D. Lt.
Martinson, Donald L. Lt. (jg) USN
Martmer, Edgar E. Capt.
Marwil, Thomas B. Lt. Comdr. USN
Matson, Guy M. USA
Mattes, Max W.
Matthews, Harry C. Lt.
Maxfield, Jack E. USA
May, Frederick T., Jr. Major
Mayne, C. H.
Merritt, Harry E. USA
Meyers, Maurice P. Major
Meyers, Soloman G. Major
Middleton, J. W. Lt.
Miller, Harry Capt.
Miller, Harry A., Jr. Capt.
Miller, Hugh Lt (jg) USN
Miller, Karl L. Capt.
Miller, Kenneth T. Major
Miller, Thomas H. Lt. Comdr. USN
Mills, Clinton C. Capt.
Min, Henry
Mindlin, R. L.
Miro, Morey D.
Mitchell, W. Bede Capt.
Moloney, J. Clarke Lt. Comdr. USN
Montante, Joseph R. Capt.
Morley, Harold V. Lt.
Morris, Roger
Morrow, Rufus C.
Morton, David G. Capt.
Muehlig, Geo. K.
Munslow, Ralph A.
Murphy, Donald J. Lt. Comdr. USN
Murphy, Frank J. Lt. Comdr. USN
Murphy, John M. Capt.
Muse, Jesse, Philip USA
Muske, Paul H. Lt.
Manning, John E. Capt.
Nagel, Oscar Capt.
Napolitano, Donald F.
Neeb, Walter, G. Capt.
Nelson, Victor E. Capt.
Newcomer, Sheldon R. Lt.
Newell, Phillip D. Lt. (jg) USN
Nichamin, Samuel J. USPHS
Nickels, Albert W. Capt.
Nickerson, I. D. Lt.
Nielsen, Aage E. Capt.
Nigg, Herbert L. Lt.
Nigro, Norman D. Lt.
Noer, Rudolph J. Major
Nolting, Wilfrid S. Lt.
Norconk, A. A. Lt. Comdr. USN
Noreen, H. A.
Novak, Walter S.
O'Donnell, Dayton H.
Lt. Comdr. USN
Olechowski, Leo W. Lt. Comdr. USN
Olenikoff, Alex
Olmstead, Geo. USA
O'Linn, Francis P.
Oppenheim, Joseph M. Lt.
Orr, Robert W.
Orris, Israel
Osius, Eugene A. Lt. Comdr. USN
Ott, Harold A. Capt.
Ottaway, John P. Lt.
Owen, Clarence I. Lt. Col.
Oxman, Albert C.
Parker, Benj. R. Lt.
Patterson, Donald S.
Patton, Henry S. Lt.
Paye, H.
Peggs, Geo. F.
Pelczar, Walter E. USA
Pelletier, Charles J.
Penberthy, Grover C. Col.
Pensler, Leslie USA
Pensler, Meyer M. Lt.
Perkin, Frank S. Major
Perlin, Michael H.
Perry, Alvin L. Lt.
Peterson, Edwin P. USA
Pettit, Vernon D.
Pfeffer, Isadore S. Lt.
Phillips, Francis J. Lt.
Pike, Donald G. USA
Pliskow, Harold Lt.
Podewza, J. W. Lt.
Poole, Marsh W. Major
Porritt, Ross J.
Pratt, L. A. Major
Prentice, Edwin W.
Price, Alvin E. Major
Procailo, Alex B. USAAC
Pugh, Howard C.
Pugsley, G. W., Jr. Capt.
Putra, Anthony M. Capt.
Pendy, John M. Lt.
Quigley, Eugene C. Capt.
Rahm, Lambert P. Capt.
Rather, L. J. USA
Ravitz, Harold G. Lt.
Raw, Frederick W. Lt.
Redding, Lowell G. Lt.
Reder, B. USA
Reid, J. Gilbert Capt.
Reid, Wesley G. Capt.
Reiff, Morris V. Lt.
Reinsh, Ernest R. Lt. Comdr. USN
Reisman, Samuel G. Lt.
Reske, Alvin A. Capt.
Rey, Geo. E. Lt.
Reynolds, Wm. F.
Rice, Clair M., Jr. Lt.
Rice, Robt. B. Lt.
Richey, Bert R. Capt.
Richmond, Marion B. USPHS
Rickert, R. G.
Riggs, Geo. T. Lt.
Riggs, Harry L. USA
Rivera, Victor USA
Robin, Herman
Robinson, H. A. Major
Rogoff, A. S. Capt.
Rom, Jack Capt.
Roman, Stanley J. Capt.
Roney, A. A. Lt.
Roney, E. H. Capt.
Root, Charles T. Major
Rosenberger, Homer G. Lt.
Rosenthal, Louis H. Lt.
Ross, Arno Lt. Comdr. USN
Ross, Benjamin C. Lt.
Ross, Hyman Lt.
Ross, Samuel J. USPHS
Roth, Theodore I. Lt. Comdr. USN
Rottenberg, Leon Lt.
Rottschafer, Gerald USA
Rowell, Robt. C. Capt.
Rowell, Wilfrid J. Capt.
Rubright, Le Roy W. Capt.
Rueger, Milton J. Capt.
Runde, Harold E. USA
Runge, Paul Wm. Lt.
Rupprecht, Emil F. Capt.
Ruskin, D. B. Lt.
Russell, Vincent Lt.
Sack, Anthony G. Capt.
Sachs, Herman K. Capt.
Sanders, John H.
Sandler, Nathaniel Capt.
Sanford, Hawley S. Capt.
Sapala, Marion A. USAAC
Sayre, Geo. S. USN
Schafer, Robt. L. Lt. Comdr. USN
Scarney, Herman D.
Lt. Comdr. USN
Schlesinger, Henry USAAC
Schmaltz, John D. USA
Schmidt, Harry E. Capt.
Schmidt, J. Robt. Lt.
Schmidt, Milton R. Lt. Comdr. USN
Schneider, Curt P. Lt. Comdr. USN
Schneider, Richard Lt.
Schoenfeld, John B.
Schofield, Norman D.
Schroeder, Carlisle F. Capt.
Schug, Richard H. Lt.
Schultz, Robt. F. Capt.
Schwab, Roland E.
Schwartz, Louis A. Lt. Comdr. USN
Schwartz, Oscar D. Major
Schwartzberg, Joseph A. Lt.

★Died in Military Service.

Wayne (Continued)

Schweigert, C. F. Lt.
Scott, Robert J. Capt.
Seliady, Joseph E. Capt.
Seski, Arthur G. USA
Shaffer, Joseph H. Major
Shapiro, Isadore A. Capt.
Shapiro, Reuben I. Lt.
Sharp, Mahlon S. Lt.
Shaver, Benjamin
Shebasta, Emil M. Capt.
Sheffrin, Peter Lt.
Shelton, Carl F. Capt.
Sheppard, Wm. B. Lt.
Sherrin, Edgar R. Lt. (sg) USN
Shewchuk, Alex P. Capt.
Shifirin, Peter G. Lt.
Shiovitz, Louis
Shulak, Irving B. Capt.
Shumaker, Edward J. Lt.
Sickels, Edward W. Lt.
Siegel, Henry Capt.
Sill, Jack A. USN
Simons, Edward J. Lt.
Skolnick, Max Lt.
Skopek, Frank S. Lt.
Skully, G. A. Capt.
Slevin, John G. Col.
Sliwin, Edward P. Lt.
Slutzy, Joseph USAAC
Small, Henry Capt.
Smeltzer, Merrill Capt.
Smith, Fred R. Lt.
Smith, Geo. E. USA
Smith, Wm. S. Capt.
Smyka, Edward J. Lt.
Snedeker, Bernard C. Capt.
Snyder, L. J. Lt.
Socall, Charles J. Capt.
Somers, D. C. Major
Sorock, Milton Capt.
Sorum, Eugene B. USN
Spalding, Edward Lt. Col.
Sparling, Harold Capt.
Spector, Maurice J. Lt.
Spencer, Samuel
Speirs, Richard E. Lt.
Spiro, Adolph Capt.
Spitzer, Henry USA
Sprunk, Carl J. Capt.
Spurrier, Ethelbert Lt. Comdr. USN
Stack, David R., Jr. Lt.
Stageman, J. C. Capt.
Stamell, Meyer Lt.
Stammell, Benj. B. Lt.
Stamos, H. F. Lt. Comdr. USN
Stanley, Sherburn Lt.
Stebbins, Charles E.
Stefani, Raymond T. Capt.
Steffensen, Ellis H. Lt.
Steffes, Everett M. Lt.
Stein, Albert H. Lt.
Stein, Edward Lt.
Stein, Saul C. Lt.
Steiner, Max Capt.
Steinhardt, Milton J. Capt.
Steinfield, Winton
Stobbe, Godfrey D. Capt.
Stocker, Lawrence L. USA
Stockwell, Benjamin W. Capt.
Stokfisz, Thaddeus Capt.
Stoll, Edward M. Lt.
Stone, E. L.
Stone, Sanford Lt.
Strand, Martin E.
Strickroot, Fred L. Lt. (jg) USN
Sugar, Hyman S.
Sugarman, Marcus H. Capt.
Sullenberger, Neil Lt.
Summers, Wm. A. Lt.
Swaney, Colletta Lt. USN
Swartz, Fred G. USA
Sykes, Edwin M., Jr.
Sylvan, M. M. Lt.
Symons, Hyman Lt.
Szabunia, Sigmund C. USA
Szejda, J. C. Lt.
Szlachetka, Vincent E. Capt.
Taylor, Ivan B. Capt.
Taylor, Nelson N. Capt.
Taxman, Joel E. USN
Tear, Malcolm J. Lt.
Teitelbaum, Myer Capt.
Tellman, H. Clay
Tenaglia, Edward
Tenaglia, Thomas A. Lt.
Thompson, Chase S.
Thompson, Frank J.
Thompson, H. O. Capt.
Thurston, Roger G. Lt.
Timmons, John R. Capt.
Trapp, Donald G. Lt.
Troester, Geo. A. Capt.
Trombley, Joseph J., Jr. Capt.
Truog, Clarence P. Major
Truszkowski, Edward G. Lt.
Tulloch, John C. Major
Turnbull, Jack V. USA
Tuttle, Wm. M. Major
Twiggs, Leo F. Lt.
Ulrich, Willis H. Major
Van Camp, Wesley USPHS
Vangrow, Stanley
Vergosen, H. E. Capt.
Vida, Alexander Capt.
Vollmer, Geo. K. Lt.
Vroon, John
Wachs, Leonard V.
Wadsworth, George H. Capt.
Walder, Harold J.
Walker, Enos G. Major
Wallman, C. H. Lt.
Wanless, Loren E. Lt.
Ward, W. Paul
Warner, Harold W. Lt. Comdr. USN
Warner, Wm. J. Lt.
Warnke, Robt. D. Capt.
Warren, John W., Jr.
Warren, Lloyd P. USPHS
Warren, Wadsworth Major
Watson, Douglas J. Lt.
Watters, F. L. Capt.
Watts, Frederick B. Capt.
Wax, John H. Capt.
Webb, Carl W.
Webster, John E. Major
Weed, Milton R. Capt.
Weeks, Don J. USN
Weimers, Eugene
Weinberg, Jacob D. USA
Weisberg, A. Allen Capt.
Weisberg, Jacob Capt.
Weisberg, Ralph J. Lt.
Weiss, Joseph G.
Wentz, Arthur E.
Wessels, Robt. R. Lt.
West, Robt. H. Lt.
Weston, Horace L. Capt.
Whalen, E. P. USA
Wheeler, Stewart C.
White, Prosper D., Jr. Capt.
Whitehead, Leston S. Capt.
Whitely, Robt. K. Lt.
Whitney, Rex. E. USAAC
Wiechowski, Henry E. Lt.
Wiener, Israel Capt.
Wietersen, Fred K. Lt.
Wilcox, L. F. Major
Wildgen, Bernard C. USN
Wilhelm, Seymour K. USA
Williams, F. R. Lt.
Williamson, Edwin M. Capt.
Williamson, Wm. P. Lt.
Willson, Wesley W. Major
Wilson, C. Stuart Major
Wilson, M. S. Comdr. USN
Wilson, Walter J., Jr. Capt.
Wiltberger, Benj. Lt.
Winfield, James M. Lt. Col.
Winsor, Carlton W. Capt.
Winton, Geo. Lt.
Wishropp, Edward A. Lt. Comdr. USN
Witter, Joseph A. Capt.
Woodward, T. E. Lt.
Worthington, Ralph USA
Wreggit, Winston R. Capt.
Wright, Robt. R.
Wunsch, Richard E. Lt.
Wyman, C. C. Lt. Col.
Wynes, Maurice C.
Wytowich, Walter S.
Yetzer, Wm. J. USA
York, Fred P. Lt. Comdr. USN
Young, Don A. Lt.
Young, Donald C. Lt. Comdr. USN
Young, Lloyd B. Lt. Comdr. USN
Yott Wm. J. Lt.
Zabinski, Edward J. USA
Zawadski, Edward S. USA
Zbudowski, Alexander S. Capt.
Zbudowski, Myron R. Capt.
Zimmerman, I. J. Capt.
Zuokowski, Sigmund Capt.

Wexford-Kalkaska-Missaukee

Albi, Rilo
Albi, William Major
Daugherty, Robert Lt.
Hoagland, F. L. Lt.
Inman, John C. Lt.
Moore, G. P. Major
Showalter, L. E. Capt.

ANNUAL SESSION OF THE COUNCIL, MSMS

January 28 and 29, 1944

Highlights of the Session

- Membership of State Society at an all time high—4786 (including 1142 Military Members).
- Annual reports of Secretary, Treasurer, Trustee, Editor, and the three Committees of The Council received.
- E.M.I.C. Program: Payment to Doctors of Medicine through Michigan Medical Service approved and referred for action to U.S. Children's Bureau.
- Psychiatric Clinic in connection with Wayne University School of Medicine discussed.
- M.S.M.S. Postgraduate Medical Education Foundation: Contribution of $100 from an anonymous member of the Society received with thanks.
- Michigan Health Council reported as a new and active force for good in Michigan health circles; M.H.C. presents a forward-looking public relations program.
- Second Annual Postgraduate Industrial Medical and Surgical Conference scheduled for April 6, Rackham Memorial, Detroit.
- Auditor's report for 1943, and Budget for 1944, approved.
- Secretary, Treasurer, and Editor elected.

FIRST MEETING

Friday, January 28, 1944—10:20 A.M.

1. *Roll Call*—The meeting was called to order by V. M. Moore, M.D., Chairman, with all members present except Dean W. Myers, M.D., Ann Arbor.

2. *Minutes.*—The minutes of the Executive Committee meeting of December 16, 1943, were read, and Item 8 was corrected, on motion of Drs. Huron-Sladek, and carried unanimously. These minutes together with the minutes of The Council meetings of September 20-23, 1943 and of the Executive Committee meetings of September 29 and November 4, were approved as published, on motion of Drs. Beck-Umphrey. Carried unanimously.

SECRETARY'S ANNUAL REPORT, 1943

3. *Secretary's Annual Report* was presented by Dr. Foster, as follows:

I herewith submit the report of the Secretary for 1943—the second World War II yearly report.

Membership

During the past year the first real impact of the war was noted in our membership. Since most available practicing physicians are now in the armed forces, little change may be expected in the number of paying members during the remaining war years.

In 1943 there was a total of 4,786 members, including sixty-five Emeritus, Honorary and Retired members and 1,142 Military members. The total paid memberships were 3,579 with net dues of $37,062.48 accruing to the Society. The number of members with unpaid dues in 1943 was thirty-seven. The membership tabulation for the years 1942 and 1943, showing net gains and losses, unpaid dues and deaths is as follows:

MEMBERSHIP RECORD 1943

	1942	1943	Military	Loss	Unpaid	Deaths
Allegan	24	19	3	5	2	....
Alpena-Alcona-Presque Isle	20	10	6	10	1	1
Barry	13	9	4	4	....	....
Bay-Arenac-Iosco	70	49	26	21	2	1
Berrien	55	52	11	3	....	....
Branch	21	13	7	8	....	....
Calhoun	99	75	39	24	....	3
Cass	14	12	3	2	....	....
Chippewa-Mackinac	21	16	8	5	....	....
Clinton	12	10	4	2	....	....
Delta-Schoolcraft	24	19	5	5	1	....
Dickinson-Iron	19	15	5	4	....	1
Eaton	29	20	7	9	....	2
Genesee	188	141	50	47	1	3
Gogebic	23	19	2	4	....	....
Grand Traverse-Leelanau Benzie	41	32	10	9	....	....
Gratiot-Isabella-Clare	40	27	12	13	....	....
Hillsdale	24	20	6	4	1	....
Houghton-Baraga-Keeweenaw	36	32	7	4	....	1
Huron	11	11	....	....	....	....
Ingham	153	127	35	26	1	1
Ionia-Montcalm	42	30	9	12	1	1
Jackson	92	75	25	17	....	2
Kalamazoo	118	73	44	45	3	1
Kent	239	191	76	48	....	3
Lapeer	15	10	3	5	....	....
Lenawee	39	29	15	10	....	1
Livingston	16	12	5	4	....	....
Luce	11	8	3	3	....	....
Macomb	39	34	7	5	1	....
Manistee	13	9	3	4	....	....
Marquette-Alger	36	30	9	6	....	....
Mason	13	10	3	3	1	....
Mecosta-Osceola-Lake	15	12	3	3	....	....
Medical Society of N. Central Counties	19	13	2	6	1	....
Menominee	13	9	3	4	....	....
Midland	16	14	2	2	....	....
Monroe	39	27	11	12	1	....
Muskegon	81	61	19	20	....	4
Newaygo	10	10	2	....	....	1
Northern Michigan	31	31	4	....	1	....
Oakland	148	111	42	37	1	1
Oceana	12	9	3	3	....	....
Ontonagon	7	5	1	2	....	1
Ottawa	32	26	5	6	1	1
Saginaw	96	71	32	25	....	....
Sanilac	15	11	2	4	....	....
Shiawassee	29	16	11	13	....	2
St. Clair	54	46	6	8	....	1
St. Joseph	22	16	10	6	....	....
Tuscola	25	23	4	2	....	....
Van Buren	25	20	8	5	1	....
Washtenaw	179	155	44	24	4	2
Wayne	1945	1634	471	311	12	10
Wexford-Missaukee	22	20	5	2	....	....
	4445	3579	1142	866	37	44
	3579					
	866					

Deaths During 1943

We regretfully record the deaths of the following forty-four members during 1943:

Alpena County—Leo F. Secrist, M.D., Alpena.

Bay County—Gaillard H. Healy, M.D., Bay City.

Calhoun County—Willoughby L. Godfrey, M.D., Battle Creek; John H. Kellogg, M.D., Battle Creek; Raymond D. Sleight, M.D., Battle Creek.

Dickinson-Iron—T. E. Camper, M.D., Corunna.

Eaton County—E. M. Paine, M.D., Grand Ledge; C. A. Stimson, M.D., Eaton Rapids.

Genesee County—Gordon H. Bahlman, M.D., Flint; Hugh W. Graham, M.D., Mt. Morris.

Gratiot-Clare—Leslie A. Howe, M.D., Breckenridge.

Houghton County—Wm. P. Scott, M.D., Houghton.

Ingham County—★Ralph Sullivan, M.D., Lansing.

Ionia-Montcalm—Frank Braley, M.D., Saranac.

Jackson County—H. A. Brown, M.D., Jackson; E. S. Peterson, M.D., Jackson.

Kalamazoo County—R. U. Adams, M.D., Kalamazoo.

Kent County—E. E. Dell, M.D., Sand Lake; D. B. Lanting, M.D., Grand Rapids; John R. Roger, M.D., Grand Rapids.

Lenawee County—A. D. Clark, M.D., Adrian.

Muskegon County—H. B. Loughery, M.D., Muskegon; R. G. Olson, M.D., Muskegon Hts; Carl Pangerl, M.D., Muskegon Hts; A. A. Spoor, M.D., Muskegon

Newaygo County—W. H. Barnum, M.D., Fremont.

Oakland County—S. W. Osgood, M.D., Clawson.

Ontonagon County—C. F. Whiteshield, M.D., Trout Creek.

Ottawa County—G. D. Bos, M.D., Holland.

St. Clair County—J. F. Waltz, M.D., Capac.

Shiawassee County—Edward J. Carney, M.D., Durand; I. W. Green, M.D., Owosso.

Washtenaw County—James R. Breakey, M.D., Ypsilanti; Norman R. Kretzschmar, M.D., Ann Arbor.

Wayne County—George C. Chene, M.D., Detroit; Guy L. Connor, M.D., Detroit; John J. Corbett, M.D., Detroit; Joseph DeHoratiis, M.D., Detroit; Raymond B. Hoobler, M.D., Detroit; Frank A. Kelly, M.D., Detroit; Anton Ottrock, M.D., Detroit; Fred W. Phillips, M.D., River Rouge; J. H. Sparks, M.D., Detroit; John T. Watkins, M.D., Detroit.

Financial Status

On December 31, 1943, the Michigan State Medical Society books were audited by Ernst & Ernst.

Their published report will reveal the following financial conditions of the Society: Assets were listed at: $62,255.24, and are $3,821.70 less than a year ago. The Net Worth is: $40,828.21 compared to $40,153.21, showing an increase of $675.00.

The income from dues was: $42,357.00 of which $5,294.52 was allocated to THE JOURNAL. This allocation produced a JOURNAL "profit" of $3,000.77. Interest was received in the amount of $978.78, and a miscellaneous income of $40.69, produced a total income of $41,082.72. This is a decerase of $7,901.64 from a year ago.

The Society expenses totaled $51,470.98. Provision for deferment of dues paid by military members made another deduction of $1,800. This left a deficit of $12,188.26 on the operation of the Society for the fiscal year.

Securities—The Security portfolio consists of high grade bonds, approximately 50 per cent of which are in U. S. Savings and Defense Bonds. The quoted market price of the securities on December 26, 1942, was $22,452.00 as compared with $22,979.50 as of December 31, 1943. Income received during the year amounted to $715.80.

Medical Defense Funds—The balance on hand December 27, 1942, was $3,548.67. Interest in the amount of $260.00 and profit from the sale of security of $106.25 and the increase value of securities of $60.00, makes a total of $3,974.92. Expenses amounted to $402.00. These consisted entirely of legal fees leaving a trust balance on December 31, 1943, of $3,572.92. This represents an increase of $24.25.

Journal—THE JOURNAL had allocated to it $5,294.52 from members' dues. Other incomes were from subscriptions, advanced reprint sales, advertising sales and JOURNAL cuts, making a total income of $20,880.15. The expenses included the Editor's salary and expense amounting to $2,100.00, printing and mailing of THE JOURNAL $11,464.48, and these with other relatively small expenses made a total of $17,879.38. This was $3,000.77 over the budget estimate. Without the allocation to THE JOURNAL from members' dues there would have resulted a loss of $2,293.75 in the operation of THE JOURNAL for the year.

Summary—The financial statement of the Michigan State Medical Society for 1943 reflects vividly the great impact of the war on our organization. With 1,137 members in the Army and Navy, the remission of dues represents a loss in income from this one source of $13,644.00 per annum.

The 1943 Annual Session

The 1943 Annual Meeting was held at the Statler Hotel, Detroit, in September, with 1,142 members serving with the forces, and many overseas, a smaller than average registration was anticipated. The total registration, however, was 2,002, a remarkable wartime attendance, which taxed to the limit the hotel facilities.

The General Assembly programs with discussion Conference, were continued in the 1943 Session and met with the same popular approval of the past three years.

The limited exhibit facilities in Detroit precluded the development of a Scientific Exhibit.

The policy of bringing to the Scientific Assembly out-of-state essayists of national and international reputation, was continued. Despite the unusual expense incurred in maintaining the high standard of the Michigan meeting with twenty-two visiting out-of-state speakers, a substantial profit accrued to the Society as a result of the well-developed technical exhibit. The number of available technical exhibit booths, however, was considerably smaller in 1943. This was due to the more limited facilities in Detroit.

Anticipated transportation difficulties failed to in any way disrupt the plans of either the Scientific program or technical exhibit.

The registrants at the convention displayed their keen appreciation to the exhibitors and gave them very generous attention.

County Society Secretaries' Conference

One conference of secretaries of the component county medical societies was held in Lansing on January 24, 1943. Due to wartime restrictions, no conference was scheduled on the occasion of the Annual Meeting in Detroit, as had been the custom in previous years.

The program of the January Conference was devoted to subjects of a war character: meeting military, research, industrial, and civilian needs, temporary licenses and dislocating of physicians, poison gas warfare, and related subjects. The meeting was attended by 82 persons, including 32 county society secretaries.

Committees

Time and space do not permit a detailed account of committee activities which was maintained at prewar level.

1943 was a legislative year during which the Legislative Committee had to consider over 50 bills affecting the medical profession. All bills detrimental to medicine and public health failed to pass, and a number of good health measures were placed on the statute books. These results give evidence of the splendid work of the committee.

The Procurement and Assignment Committee, having processed most of the physicians available for military duty, were busily engaged in a program of relocation of physicians in critical areas throughout the State.

The Committee on Postgraduate Medical Education continued its program in the extra-mural centers, including the five Upper Peninsula centers established in 1941, on an annual four-day schedule instead of an eight-day one. The shortage of physicians, especially in the smaller communities, necessitated this shorter, more concentrated program.

★Died in Military Service.

A perusal of the minutes of all of the committees of the Society during 1943, would elicit an appreciation of the tremendous contribution of time and effort made by the many members of the State Society to the development of its many splendid projects.

Society Activities

Due to the shortage of medical manpower in most communities, some county societies have found it necessary to hold fewer meetings and some have replaced regular meetings, in the spring and autumn, with extra-mural postgraduate conferences.

Contact with fifty-five county units has been maintained throughout the year by the regular Councilor and Officer visitations, and by the issuance of fifteen secretary letters. Of these eight were sent to County Presidents and Secretaries, and seven went to every member of the Society.

The members of the State Society now enter upon another year of activity which promises to present more and bigger problems. Physicians on the home front have a responsibility to carry on the practice of medicine with greatly depleted ranks, and to maintain for themselves and their colleagues in the armed forces the traditions of American Medicine. This latter responsibility in the light of political trends calls for individual participation of every physician in some well-developed and coördinated plan of public education. Some such plan is necessary if we, as a profession, properly contribute to the solution of the inevitable postwar economic and social problems of medicine. We record with pride the honor roll of nearly 2,000 Michigan doctors of medicine serving with the armed forces—a splendid record.

In conclusion I respectfully recommend that

1. In view of existing transportation difficulties, inter-society relations be maintained, in so far as possible, through communications and officer-committee-councilor contact with the various component societies.

2. The study and development of Postgraduate Refresher Courses for members returning from the armed forces, be continued and made ready for operation when needed.

3. The Society immediately embark upon a suitable program of public information, either through the development of a new Department of Public Relations and Medical Service with a full-time director within the State Society, or in participation with other professional groups in a similar program on a broader basis.

4. If a new Department of Public Information be established independently by the State Society, that the name of the present "Public Relations Committee" be changed to more appropriately designate its intra-society function as set forth in the Constitution of the State Society.

Your Secretary desires to express to this Council, his sincere appreciation of its splendid coöperation during 1943; and to the committees of the Society, a hearty commendation of their sincere efforts in the successful execution of many splendid projects.

Mr. Burns and an almost completely new office personnel have been most untiring in the discharge of their many duties.

To Mr. Burns, especially for his kind coöperation, helpful suggestions and constant inspiration, and to all those who have aided so generously in the discharge of the duties of this office, your Secretary is most grateful.

Respectfully submitted,

L. Fernald Foster, M.D.
Secretary

The report was referred to the County Societies Committee.

EDITOR'S ANNUAL REPORT, 1943

4. The *Editor's Annual Report* was presented by Dr. Haughey, as follows:

In 1943, The Journal of the Michigan State Medical Society published 1,022 pages, not including four pages of cover each month. Notwithstanding shortages of labor and paper the standard of appearance and workmanship has been maintained, and the date of publication has not been too late. Some numbers have been unavoidably delayed, and for this we ask your indulgence. Abnormal times and conditions have been mostly to blame.

Seventy-seven original papers of unusually worthy material and value were published, with a good interspersing of illustrations. Several of our papers have been abstracted in other journals or reviews, two copied in full and one translated into Spanish.

We have prepared and published sixty editorials, which were submitted routinely to the Publication Committee, and the Editor wishes hereby to acknowledge gratitude to this Committee, especially Dr. Perkins and Mr. Burns, for many helpful criticisms and suggestions. We have tried to interpret the belief of our Society and our membership in regard to the trying times through which we are passing, and to suggest logical procedures in guiding our actions and reactions.

There have been ninety-two book reviews in which we attempted, in few words, to give a just appreciation and criticism of the books submitted. A number of friends have kindly helped in this service and we are appreciative of these labors. A proper book review takes considerable time and studied contemplation, as well as precise comments.

We have published thirty-six War Bulletins trying to give a true picture of medicine in our war effort, and the problems to be solved as well as the suggested solution as arrived at by many of our contemporaries. You and Your Business has been a handy title to cover forty-nine articles of miscellaneous nature, but intimately connected with economics, social and other problems of especial interest to the medical profession.

We have published for The Michigan Department of Health fifty-eight notes and comments having to do with public health and our contacts with those problems.

Thirty-seven deaths have been catalogued, including two former presidents of the Michigan State Medical Society and many men of unusual prominence.

We are proud of our Journal, and believe it is now as always filling a distinct service to the profession, and is worthy of its cost even if it does not always carry all of its own financial load.

Respectfully submitted,

Wilfrid Haughey, M.D., *Editor*

The report was referred to the Publication Committee.

ANNUAL REPORT OF COUNTY SOCIETIES COMMITTEE, 1943

5. *Report of County Societies Committee* was presented and discussed by Dr. Sladek, Chairman, as follows:

1. The County Societies Committee of the Council met in Detroit on Thursday, January 27, 1944. The meeting was called to order at 8:45 p.m. by Chairman Sladek. Present were Drs. Sladek, Riley, Hubbell, and Perkins.

2. The Brasie Resolution re Osteopaths in Michigan

Medical Service was discussed. It was the sense of the Committee that the report of the Special Committee should be presented to The Council as a whole.

3. Situation in Sault Ste. Marie.—A. H. Miller, M.D., Councilor, 12th District, discussed in full detail the situation in Chippewa-Mackinac County. Motion of Drs. Hubbell-Riley that the appeal be referred to the Ethics Committee which should be instructed to make a later report to The Council. Carried unanimously.

4. Postwar Postgraduate Program. Letter from Oregon State Medical Society was read. Motion of Drs. Riley-Perkins that the matter be turned over to the Postgraduate Medical Education Committee. Instructions to Executive Secretary Burns to answer the questionnaire giving the present setup and to tell Oregon that at present we have no fixed plans but this is being turned over to the Postgraduate Medical Education Committee. Carried unanimously.

5. Relocation of physicians. Letter from Deputy Commissioner of Health Thiehoff and letter to the late H. Allen Moyer, M.D., from T. A. Parran, USPHS, were read. Motion of Drs. Perkins-Riley that the letter be approved, carried unanimously. The Federal Legislation Bulletin 29, page 17, contains provisions that should take care of postwar postgraduate situations. Carried unanimously. It is the sense of the committee that we should approve of Federal aid in the relocation of physicians into critical areas.

6. Proposed consolidation of administrative boards. Letter from Roy C. Perkins, M. D., was read. Motion of Drs. Riley-Hubbell that the letter be received and placed on file. Carried unanimously.

7. Report re discontinuance by M.T.A. of diagnostic X-ray services. This was fully discussed but no action taken, inasmuch as the services have not been discontinued.

8. Suggestion that the M.C.C.C. be placed under the State Department of Health. No definite information and no action.

9. Medicolegal cases outstanding. Motion of Drs. Hubbell-Perkins, that the report be received and filed. Carried unanimously.

10. Red Cross Aid to health departments during flu epidemics. Discussed and tabled.

11. Letter from Mary S. Kitchel, M.D., Grand Haven. Motion of Dr. Riley that the situation be taken care of by Councilor V. M. Moore in coöperation with L. A. Potter of the State Department of Health. Carried unanimously.

Respectfully submitted,

E. F. Sladek, M.D., *Chairman*
Wilfrid Haughey, M.D.
R. J. Hubbell, M.D.
R. C. Perkins, M.D.
P. A. Riley, M.D.

The report was referred to the Finance Committee.

ANNUAL REPORT OF PUBLICATION COMMITTEE, 1943

6. *Report of the Publication Commitee* was presented by Dr. Morrish, Chairman, as follows:

1. The Publication Committee of the Council met in Detroit on Thursday, January 27, 1944. The meeting was called to order at 8:15 p.m. by Chairman Morrish. Present were Drs. Morrish, Miller, Beck, Witwer, Editor Haughey, and Mr. Burns.

2. Interview with Harry R. Lipson, prospective salesman of advertising space in M.S.M.S. Journal. Mr. Lipson discussed prospects for obtaining new business, assignment of prospects, rates of commission, on new business and on renewals of same, and formulation of a contract to cover his services in behalf of the M.S.M.S. Journal. Motion of Drs. Witwer-Beck that this Committee recommend that a written contract be entered into with Mr. Lipson whereby he will obtain new advertising accounts for the M.S.M.S. Journal for a commission on said new business he obtains and on renewals of same, and that this is in no way to affect present arrangements with the Coöperative Medical Advertising Bureau; and that when an agency commission is allowed, Mr. Lipson is to receive a commission on the net balance. Carried unanimously.

Prospect list for Mr. Lipson. A list of prospects to be contacted by Mr. Lipson was approved. The advertisements of the above concerns are each to be accepted subject to the approval of the Publication Committee.

Motion of Drs. Beck-Witwer that Editor Haughey and Secretary Foster be instructed to contact the C.M.A.B. concerning prospective advertising accounts which have lain dormant for years, with a view to having these turned over to Mr. Lipson for action. Carried unanimously.

3. Auditor's report re The Journal. The report of Ernst & Ernst was studied by the committee, which also studied the reprint report for the year 1943. Motion of Drs. Beck-Witwer that these reports be accepted, was carried unanimously.

4. Proposed budget of The Journal for 1944. The Budget was studied, approved, and referred to the Finance Committee, on motion of Drs. Beck-Witwer. Carried unanimously.

5. Paper reductions. The matter of limiting monthly features and otherwise insuring a journal of not more than 84 pages per month, to conserve paper, was discussed. The Committee left this to the discretion of the Editor to hold The Journal down to 84 pages per month.

The Managing Editor of The Journal was instructed to eliminate complimentary copies to as many detail men and others as possible for the duration, to save paper.

6. Request for advertising space.

(a) Harrower Laboratories, Inc. (institutional copy re endocrine products) 12 quarter pages. After detailed study, motion was made by Drs. Miller-Witwer that these advertisements be accepted. Carried unanimously.

(b) The Wander Company (Ovaltine) 6 pages. Motion of Drs. Witwer-Beck that these advertisements be accepted. Carried unanimously.

(c) Schering Corporation (Estinyl). This advertisement was accepted by the Committee members present.

(d) Otis E. Glidden Company (Zymenol) 12 pages. Motion of Drs. Witwer-Beck that this advertising be accepted. Carried unanimously.

(e) I. W. Harper, 6 pages. Motion of Drs. Miller-Witwer that these pages be accepted. Carried unanimously.

Motion of Drs. Beck-Miller that on a mail ballot, the affirmative votes of four of the five members of the Publication Committee shall be necessary for approval of an advertisement for the M.S.M.S. Journal. Carried unanimously.

7. Refund of $1,623.65 for 1943 from the C.M.A.B. was reported. Motion of Drs. Beck-Witwer that the Chairman be authorized to send a letter of congratulation and appreciation to C.M.A.B.. Carried unanimously.

8. Request for complimentary copies of M.S.M.S. Journal:

(a) Dr. Martha M. Eliot, U. S. Children's Bureau. This was discussed and the motion of Drs. Miller-Beck that Dr. Eliot be advised of the subscription rate of the M.S.M.S. Journal, was carried unanimously.

(b) American Hospital Association. This was approved on an exchange basis, the Hospital Journal to be sent to Editor Haughey, motion of Drs. Beck-Miller. Carried unanimously.

(c) Medical School, Southwestern Medical Foundation, and University of Illinois Medical School, and "R.N.": Motion of Drs. Beck-Witwer that due to the paper shortage, these requests for free subscriptions be not granted. Carried unanimously.

9. Communication from L. A. Campbell, M. D., of Saginaw, opposing advertising of rental of radium was thoroughly discussed. The Executive Secretary was instructed to write the A.M.A. concerning its policy and the reasons for adopting same. Motion of Drs. Witwer-Beck that this question be referred to the Executive Committee, after the report of the A.M.A. shall have been received, with the respectful recommendation of the Publication Committee that if the J.A.M.A. does not accept this advertising, the J.M.S. M.S. do not accept it. Carried unanimously.

10. Prospective advertisers: the Committee selected a number of prospective advertisers whose messages have appeared in other medical publications, and authorized contact with these firms.

Respectfully submitted,

R. S. Morrish, M.D., *Chairman*
O. O. Beck, M.D.
A. H. Miller, M.D.
E. R. Witwer, M.D.

The report was referred to the County Societies Committee.

ANNUAL REPORT OF FINANCE COMMITTEE, 1943

7. *Report of Finance Committee* was presented and discussed by Dr. Umphrey, Chairman, as follows:

1. The Finance Committee of the Council met in Detroit on Thursday, January 27, 1944. The meeting was called to order by Chairman C. E. Umphrey, M.D., at 8:15 p.m., the following being present: Drs. Umphrey, Huron, Barstow, DeGurse, Moore, Stryker, Brunk, Keyport, Ledwidge, and Secretary Foster.

2. On motion of Drs. Huron-Barstow, the reports of Ernst & Ernst were received and ordered filed. Carried unanimously.

3. On motion of Drs. Stryker-Huron, several items totalling $116.58 were ordered stricken off the books as doubtful Accounts Receivable. Carried unanimously.

4. On motion of Drs. DeGurse-Barstow the bills payable were allowed and ordered paid. Carried unanimously.

5. On motion of Drs. Barstow-Stryker, the expenses of the keyman to the January 30 Information Conference were ordered paid, according to the precedent established in former years. Carried unanimously.

6. On motion of Drs. DeGurse-Stryker, the luncheon expense of all guests was ordered paid. Carried unanimously.

7. The Luce-Christian Resolution, presented to the 1943 M.S.M.S. House of Delegates and aimed at better public relations for the medical profession, was discussed thoroughly. Motion of Drs. Huron-Stryker that it is the sense of the Finance Committee that the recommendations of the Luce-Christian Resolution including the establishment of a Washington office are being satisfactorily implemented through coöperation of the M.S.M.S. with The Michigan Health Council. Carried unanimously.

8. Request for exemptions of Federal taxes on M.S.M.S. Foundation for Postgraduate Medical Education. Motion of Drs. Huron-Barstow that no request be made at this time. Carried unanimously.

9. Budget:

(a) On motion of Drs. Huron-Stryker, the $10 assessment was made a special budgetary item for public relations and education. Carried unanimously.

(b) It was the sense of the Finance Committee that there was no provision for the elimination of the assessment of any active member on the basis of income.
It was also the sense of the Committee that the assessment should not apply to Emeritus Members, although voluntary contributions from such members to this fund would be acceptable.
Letter from Wayne County Medical Society asking on what basis the fund created by the special assessment will be spent. Dr. Umphrey reported that he had presented a statement relative to this matter to The Council of the Wayne County Medical Society. No further action was deemed necessary.

(c) On motion of Drs. DeGurse-Huron, the usual expense accounts of the Secretaries were ordered continued. Carried unanimously.

(d) On motion of Drs. Stryker-Barstow, an increase of $10 per month was accorded each of the following office personnel: Miss W. C. Shepline, Miss Helen Schulte, Miss Eileen Ayers, Miss Geraldine Chapman. Carried unanimously.

(e) On motion of Drs. Stryker-DeGurse, the Finance Committee approved the Budget and respectfully submitted it to The Council.

Respectfully submitted,

C. E. Umphrey, M.D., *Chairman*
W. E. Barstow, M.D.
T. E. DeGurse, M.D.
W. H. Huron, M.D.
O. D. Stryker, M.D.

The report, excluding Bills Payable, was referred to the Publication Committee.

Bills Payable.—Motion of Drs. Ledwidge-Perkins that the report of the Finance Committee recommending approval and payment of Bills Payable be adopted. Carried unanimously.

FEDERAL MATERNAL-INFANT CARE PROGRAM

8. *Federal Program of Obstetric-Pediatric Care for Servicemen's Wives* (Special Committee: Drs. Ledwidge-Keyport-Foster).—Chairman Ledwidge reported for his Special Committee, outlining contacts and work with Dr. E. F. Daily, Michigan Medical Service, Auditor General Brown, and with the Executive Committee of The Council. He reported that the Board of Directors of Michigan Medical Service, on January 26, had tabled the proposition of coöperation until a decision is reached by the U. S. Children's Bureau concerning payment to doctors through M.M.S.

At the last meeting of The Council of the State Society, September 23, in Detroit, this subject was discussed with Edwin F. Daily, M.D., of the Federal Children's Bureau. Following this discussion, Dr. Daily requested an outline of the plan as proposed, September 28, at a joint meeting of the Executive and Medical Advisory Committee of Michigan Medical Service. They discussed both the plan and Dr. Daily's request. The attendance at this meeting, and the notes on this subject taken from the official minutes of the meeting are as follows:

"Present: Robert Baker, M.D.; A. S. Brunk, M.D.; E. I. Carr, M.D.; W. B. Harm, M.D.; Stanley W. Insley, M.D.; R. L. Novy, M.D.; also P. L. Ledwidge, M.D., speaker of the House of Delegates of the Michigan State Medical Society; Jay C. Ketchum; and C. H. Coghlan. Absent: Wilfrid Haughey, M.D., and Wm. J. Norton.

"Obstetrical and Pediatric Care for Servicemen's Families.

"Dr. Ledwidge informed the committee that tentative proposals had been discussed regarding some possibility of utilizing Michigan Medical Service as a means of presenting an alternative to the U. S. Children's Bureau and the Michigan Department of Health's program for servicemen's wives.

"After general discussion of all phases of such a proposal, motion was made, supported, and carried: That the sense of discussions of this meeting and a tentative proposal be conveyed to Dr. Ledwidge for consideration of The Council of the Michigan State Medical Society, and that this group reconvene at the call of the President to further consider or carry out the requests of The Council."

A questionnaire was then sent to each active member of the MSMS, asking the following:

1. Are you in favor of accepting federal funds for the care of wives and infants of enlisted men?
2. If so, which agency do you prefer to dispense the funds?
   (a) Michigan Department of Health.
   (b) Michigan Medical Service.
3. Do you do obstetrics?
4. Do you do pediatrics?

A report of this questionnaire, and general discussion of the problems, as taken from the minutes of the Executive Committee of the Council at its November 4 meeting are as follows:

"Program of Obstetric-pediatric care for servicemen's wives. The Special Committee (Drs. Ledwidge, Keyport, Foster) reported through Chairman Ledwidge, who stated that the returns on the recent poll, up to November 4, 1943, were as follows:

	Yes	No	No answer
Question 1.	802	746	267
Dept. of H.M.M.S.			
Question 2.	132	814	840
Question 3.	1053	673	76
Question 4.	969	576	113
Total number of returns			1,827

Dr. Ledwidge also presented a detailed plan developed by executives of Michigan Medical Service for possible presentation of the U. S. Children's Bureau. Dr. Ledwidge reminded the Executive Committee of the Council that Edwin F. Daily, M.D. of the U. S. Children's Bureau had stated that if Michigan Medical Service were utilized for this project, it would merely be a disbursing agency, with the finances being given to it by the State Department of Health; Dr. Ledwidge stated he was not enthusiastic over such use of Michigan Medical Service. He asked: "What stand shall the State Society take on any coöperation?"

"The matter was discussed by Drs. Haughey, Beck, Brunk, et al. The Oakes Resolution, as presented to the 1943 Michigan State Medical Society House of Delegates, was read; the action taken by the House of Delegates was also reviewed.

"Motion of Drs. Umphrey, Ledwidge that the Special Committee be instructed by the Executive Committee of the Council to carry out the dictates of the Michigan State Medical Society House of Delegates; that the Michigan State Medical Society is opposed to direct payment of physicians by government, and that the Special Committee be instructed to continue to negotiate with the State Department of Health for the disbursement of these monies through Michigan Medical Service; that pending further negotiations, members of the Michigan State Medical Society may properly,

(a) Sign the blanks to provide for *Hospital* Service, giving the care gratis; or

(b) Sign the blanks and accept the government fee for *medical* care; or

(c) Decline to participate in the program *as they see fit.*

This motion was thoroughly discussed.

"Substitute motion was offered by Drs. Umphrey-Brunk that the above ideas be given to the Special Committee and that they be empowered to write and edit these ideas in the form of a letter, and that they be authorized to negotiate further with the Michigan State Department of Health; carried unanimously."

Dr. Vernor Moore, Dr. Alexander Campbell, and Dr. Lillian Smith worked out a plan, reported November 15. This plan was presented to the Executive Committee of Michigan Medical Service by Dr. Brunk on November 17, and was discussed and approved informally.

It was then presented to the Board of Directors of M.M.S. at their December 8, 1943 meeting. Extracts from that meeting are as follows:

"Present: Leon Bogart, M.D.; A. S. Brunk, M.D.; E. I. Carr, M.D.; E. F. Collins, M.D.; B. R. Corbus, M.D.; E. H. Fletcher; Robert Greve; W. B. Harm, M.D.; Wilfrid Haughey, M.D.; Stanley W. Insley, M.D.; P. L. Ledwidge, M.W.; V. M. Moore, M.D.; Wm. J. Norton, R. L. Novy, M.D.; Philip Riley, M.D.; also Jay C. Ketchum; Frank M. Cordero; C. H. Coghlan; and Henry S. Hosmer. Absent: Robert Baker, M.D.; Wm. J. Burns; H. H. Cummings, M.D.; Ralph Hueston; Wm. A. Hyland, M.D.; Claude R. Keyport, M.D.; John Reid; Dora H. Stockman; O. D. Stryker, M.D.

Maternity and Pediatric Program.

Dr. Ledwidge reported on the maternity and pediatric program of the Children's Bureau.

While the minutes in this regard are very meager, the matter was thoroughly discussed and given wholehearted approval by members of the board. There was not a quorum present at this meeting.

The plan was then presented to Auditor-General V. J. Brown at a meeting on December 29. Present at this meeting were Auditor-General Brown, Mr. Jay Ketchum, and Drs. Brunk, Novy, Umphrey, and Ledwidge. The report of this committee is set forth in a letter from Mr. Ketchum under date of January 4. This letter was approved by Drs. Keyport, Foster, Ledwidge, and Chairman of the Council Moore. This action was reported to Dr. Smith of Michigan State Department of Health, as per letter of January 11. It was approved by Dr. Smith, and the new proposal sent on to Washington.

At a meeting of the Board of Trustees of Michigan Medical Service on January 26, a letter from Dr. Moore, making formal request for Michigan Medical Service to put the plan into effect, was read. A motion that the Board of Trustees stand ready to do this was tabled until the report from the Federal Children's Bureau has been received.

Respectfully submitted,

P. L. Ledwidge, M.D., *Chairman*
C. R. Keyport, M.D.
J. Leonard Foster, M.D.

The report was referred to the Finance Committee.

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9. *Burns Case.*—The special committee (Drs. Brunk-Hyland-Ledwidge-Umphrey) reported through Chairman Brunk on the legal talent selected and the progress of the case. Dr. Brunk stated that Attorney Chawke had been invited to Saturday's meeting of The Council to present the legal aspects. The Chairman recom-

mended that a dignified statement for release to the newspapers should be developed. Further, Dr. Brunk referred to newspaper stories on this matter in which Mr. Burns invariably is described as the Executive Secretary of the Michigan State Medical Society but Mr. Hooper seldom is mentioned as Executive Secretary of the Michigan Association of Osteopaths.

Motion of Drs. Huron-Haughey that the report of the committee and its recommendations, be approved. Carried unanimously.

Motion of Drs. Haughey-Witwer that the special committee of which Dr. Brunk is Chairman be authorized and instructed to prepare the statement and to contact the newspapers and wire services as recommended by Dr. Brunk. Carried unanimously.

M.S.M.S. COMMITTEE REPORTS

10. *Reports of M.S.M.S. Committees*:

(a) *Postgraduate Medical Education Committee,* meeting of November 23, 1943. The minutes were read and discussed. Motion of Dr. Umphrey, seconded by several, that the minutes be received and placed on file, was carried unanimously.

(b) *Postgraduate Extension Committee,* meeting of November 23, 1943. The minutes included a report on a $100 contribution to the M.S.M.S. Postgraduate Foundation by an anonymous donor. Motion of Dr. Umphrey —seconded by several—that the minutes and the $100 check be received, and that an official letter of thanks be dispatched to the generous donor. Carried unanimously.

(c) *Joint M.S.M.S.-State Bar Committee on Venereal Disease Control,* meeting of December 19, 1943. These minutes were read and on motion of Drs. DeGurse-Hubbell were approved except Item 6 describing a Michigan law controlling the sale of sulfonamides, which statute does not exist. Carried unanimously.

(Recess for Luncheon at 12:30 p.m.)

SECOND MEETING

Friday, January 28, 1:55 P.M.

10. *Report of M.S.M.S. Committee* (Continued)

(d) *M.S.M.S. Venereal Disease Control Committee* meeting of December 19, 1943. These minutes were read and Item 5 concerning the Prophylactic Kit was discussed by L. W. Shaffer, M.D., Chairman of the Committee, who answered questions propounded by the Reference Committee of the M.S.M.S. House of Delegates at its September, 1943, meeting. Dr. Shaffer felt that the present program, as proposed, offers much of value, representing 18 months' work, and should be acted upon; he stated that the kit is better than anything on the market. General discussion followed. Motion of Drs. Hubbell-Barstow that The Council accept the Committee report and give authority to the Venereal Disease Control Committee to use the following statement on the Prophylactic Kit: "This preparation has been prepared after the formula developed by the Venereal Disease Control Committee of the Michigan State Medical Society." Carried unanimously. The Chair thanked Dr. Shaffer for his attendance at this meeting and complimented the members of the Venereal Disease Control Committee for their excellent work.

(e) *Mental Hygiene Committee,* meeting of January 20, 1944. These minutes were read by Secretary Foster, who presented the Committee's request for one psychiatrist on the General Assembly program at the September, 1944 M.S.M.S. Postgraduate Conference on War Medicine. Motion of Drs. Huron-Barstow that the Committee report and recommendation be accepted. Carried unanimously. Motion of Drs. Barstow-Hubbell that the Mental Hygiene Committee be instructed to proceed with its proposed project of premarital instruction. Carried unanimously.

(f) *Child Welfare Committee,* meeting of January 20, 1944. The minutes were read and accepted on motion of Drs. Witwer-Beck. Carried unanimously.

(g) *Joint Committee of M.S.M.S.-UAW-CIO* meeting of November 16, 1943. Item 14, line 24, of these minutes read as follows: "We recommend that a *permanent* committee be provided . . ." Discussion brought out that this committee was created originally as a *temporary* committee. Motion of Drs. Barstow-Ledwidge that the Council rescind the action of its Executive Committee taken on December 16, 1943, Item 12—(b), relative to the report of the M.S.M.S.-UAW-CIO Committee so far as the word "permanent" is concerned. Carried unanimously.
Motion of Drs. Witwer-Perkins that the M.S.M.S.-UAW-CIO Committee be continued as a temporary committee. Carried unanimously.

(h) *Michigan Health Council.*—Dr. Brunk, one of the representatives of the M.S.M.S. to the Health Council, reported that the Council has held 4 meetings, has considered a mailing to other state medical societies, and has recommended a $20,000 budget, $5,000 to be contributed by the Michigan State Medical Society, $5,000 by Michigan Medical Service, and $10,000 jointly by the Michigan Hospital Association and Michigan Hospital Service. He stated that Michigan Medical Service voted to contribute to the Council when it has learned its aims and purposes; further that Michigan Hospital Service is postponing its contribution in order to ascertain how much of the $10,000 can be assumed by the Michigan Hospital Association. MHS will loan its publicist, Mr. Davis, to the Council, at no cost. Dr. Brunk stated that the State Dental Society is delaying its coöperation with M.H.C. until it ascertains what the A.D.A. thinks of the project. The matter was thoroughly discussed by Drs. Umphrey-Foster-Brunk-Huron, in which the speakers stressed that the medical profession must develop and offer a better voluntary program of medical service than can be inaugurated by government. The Chair referred the matter to the Special Committee (Drs. Keyport-Witwer-Brunk-Barstow), as a reference committee.

(i) *M.S.M.S. Radio Committee.*—A letter from Chairman R. N. DeJong outlining a possible use of stations WJR, and WKAR, through the coöperation of the U. of M. Broadcasting Service, was presented. Motion of Drs. Huron-Sladek that the proposed arrangements be approved. Carried unanimously.

(To be concluded in April issue)

ANNUAL MICHIGAN POSTGRADUATE PROGRAM FOR GRADUATES IN MEDICINE

The Michigan State Medical Society, in coöperation with the University of Michigan Medical School, Wayne University College of Medicine, the Michigan Department of Health, and the Wayne County Medical Society, announces the postgraduate courses for 1944.

INTRAMURAL COURSES

All Dates Inclusive

Anatomy	(Thursdays) March 9-June 29
Care and Treatment of Children, Recent Advances in	May 15, 16 and 17
Common Problems in Differential Diagnosis	May 15, 16 and 17
Diseases of the Blood and Blood-forming Organs	May 1-5
Diseases of the Heart	May 25, 26 and 27
Electrocardiographic Diagnosis	Nov. 6-11
Gastroenterology	May 22, 23 and 24
Laboratory Diagnosis, Clinical	April 24-28
Ophthalmology and Otolaryngology	April 20-26
Personal Courses	Throughout the year
Roentgenology	April 17-21
Therapeutics, Recent Advances	May 18, 19 and 20
Summer Session Courses	July 3-August 25

EXTRAMURAL COURSES

Ann Arbor	April 11, May 9
Bay City	March 8, April 12
Flint	April 11 and 25
Grand Rapids	April 11, May 9
Jackson	April 4 and 26
Kalamazoo	April 27, May 16
Mt. Clemens	April 12 and 26
Traverse City	April 12, May 10

Subjects

Common Endocrinological Problems.

Deviation from the Normal in Developing Children. Practical Points in Everyday Pediatrics.

Treatment of Varicose Veins.

The Problem of Abortion. Classification. Rh Factor.

Relation of Physical Findings in the Chest to the Roentgen Findings. Panel Discussion.

Recent Developments in Gastroenterology. Panel Discussion.

UPPER PENINSULA

Monday, May 22—Sault Ste. Marie, Ojibway Hotel.

Tuesday, May 23—Marquette, Northern Michigan Children's Clinic.

Wednesday, May 24—Houghton, Douglass House.

Thursday, May 25—Ironwood, St. James Hotel.

Friday, May 26—Powers, Pinecrest Sanatorium.

Program

2:30 P.M.

The interpretation of clinical laboratory procedures useful in practice—Frank H. Bethell, M.D.

The modern management of varicose veins, phlebothrombosis, and thrombophlebitis—Robert W. Buxton, M.D.

Management of venereal diseases—Robert S. Breakey, M.D.

Deviation from the normal in developing children. Practical points in everyday pediatrics—Mark Osterlin, M.D.

6:15 P.M. Dinner.

Panel Discussions.

1. Management of blood diseases. Indications for transfusion.
2. Application of developments in nutrition to general practice.

For further information, address **Committee on Postgraduate Education, Michigan State Medical Society, Room 2040, University Hospital, Ann Arbor, Michigan**

YOU AND YOUR BUSINESS

CANCER EDUCATION IN HIGH SCHOOLS

The Michigan Department of Health has recently placed in each of the 731 high schools of the state a teaching manual on cancer control. This manual was prepared in the Division of Cancer Control and grew out of experience gained in speaking to many high school students on this subject.

Interest shown by students after hearing a talk on cancer control and questions asked of biology and other science teachers indicated the need for some authoritative reference manual on the subject. It is expected that this manual after being used for a while in its present mimeographed form will be issued in a more permanent form.

Michigan is one of several states offering a cancer educational program to the schools. This is in line with the development of a general educational program. The Cancer Manual for physicians and dentists prepared and distributed by the Cancer Committee of the Michigan State Medical Society and the Michigan Department of Health will fill a long-felt need in this field. The two bulletins, "Cancer—Causes and Control," and "Cancer in Michigan," for general public use have been widely distributed. The high school manual will also serve a large and very important section of the general population.

The coöperative cancer program sponsored by the medical society and health department is unique in this country and is stimulating an increased interest in the cancer control program throughout the state.

ADMINISTRATIVE AND PROFESSIONAL PROBLEMS OF MEDICAL PRACTICE IN THE HOSPITAL.

Father Alphonse M. Schwitalla, S.J., Dean of the St. Louis University School of Medicine in an address at the Annual Meeting of the Wisconsin State Medical Society in Milwaukee, September, 1943, arrived at the following conclusions. They are particularly interesting, especially the first four:

For me, personally, I feel that I can unqualifiedly state my position briefly as follows:

1. The principle of the exclusive autonomy of the physician in rendering medical service to a patient must remain inviolable.

2. The ethical relationships defined in the principles of ethics of the American Medical Association with reference to consultations are sound and are conceived in the best and in the most lasting interests of the patient.

3. The application of these two fundamental principles to the practice of medicine by the physicians who give a general service is beset with numerous difficulties which should, however, with sufficient good will, competence, and sincerity, be resolvable in a manner conducive to the good of the patient and in conformity with elevated ideals in medical practice.

4. Plans should be studied which will make it possible for the hospitals to work towards the elimination of the salary basis of appointment of the pathologist, the radiologist, the laboratory physician, the physiotherapist and the physician anesthetist, so that these physicians may be in reality and not merely in name free professional and independently responsible agents and not agents of the institution in which they are carrying on their work.

5. A basis or a number of bases should be devised according to which a fair return on its investment and on its operating expenditures in the conduct of the various medical general service departments should be returned to the institution.

6. If these principles are reduced to a practical program, the controversies with reference to these questions which have centered in the Blue Cross Plans can and will be successfully adjusted provided that the Blue Cross Plans adhere firmly to the principle which they have adopted of guarenteeing to the participating hospitals continuing freedom in the formation and execution of their administrative policies.

SOCIAL SECURITY

WASHINGTON—(AP) Jan. 17, 1944—The social security board recommended for the first time today federal insurance to cover doctor and hospital bills.

In its eighth annual report to congress, the board said such insurance should allow a person to choose his own doctor or hospital, and preserve personal relationships between physicians and their patients.

It also should maintain professional leadership, the board said, guarantee the continued independence of non-governmental hospitals, and insure to doctors and hospitals an adequate financial return—"very probably more nearly adequate than that in customary circumstances."

The proposal was made as a part of a "comprehensive unified system" of social security which the board, headed by Arthur J. Altmeyer, believes ought to be adopted to get ready for the "sharp and sudden" social changes and readjustments which it says are around the corner.

"Whether one believes the war will end in one year or five," the report says, "the time in which to build a stronger system of social security is short."

The program outlined today includes the following provisions which the board has advocated before:

Extension of the present social security system to about 20,000,000 more persons, such as farmers, domestics and the self-employed; insurance against temporary or permanent disability, a national unemployment insurance system to replace the 51 systems of the states and territories, and protection of the social security rights of members of the armed forces.

If these provisions were added to the present old-age and survivors' insurance, the program for the first 10 years would cost 12 per cent of earnings, divided between employers and workers, the board estimated. After 10 years, as larger amounts are paid out to aged

persons and survivors, the cost would go above 12 per cent, and the board recommended that the excess be met by a federal contribution.

The board expressed belief that "the lack of adequate measures to cope with sickness and disability represents the most serious gap in provisions for social security in the United States."

COMEDY A LA MURRAY-WAGNER-DINGELL

We dedicate this story, which is Factual and Authentic, having happened in Southern Oakland County in the year of 1944, to Dr. Lillian Smith, of the Maternal Health Section of the State Board of Health; to the Children's Bureau of the U. S. Dept. of Labor; and to Messrs. Wagner, Dingell and Murray, with our profound wish that they answer for it, to that soldier's wife:

Bewildered, young, frightened, she came into Dr. S.'s office last week. Her husband was in service. She was pregnant, and having pains. She hadn't made any arrangements for servicemen's family relief. Somehow, she thought, *they* ought to have taken that upon themselves, for after all, they had made all the arrangements for her husband's induction.

Dr. S., with an office full of patients, examined her. She was in active labor, at term. She needed hospitalization, and right now. Dr. S. busied himself at the phone. X hospital was sorry, but rules prohibited the admission of service wives maternity cases (the State Board of Health refused to allow anywhere near the cost of hospitalization). Hospital Y would take her if it had to, but try to get some other accommodations; if you cannot, you must have the proper forms filled out. How long did that take? Ordinarily, three days. American Red Cross was called, but the woman in charge of those matters was out, wasn't expected for half an hour. The pains were becoming stronger, more frequent. A half hour passed, the Red Cross called again, the woman contacted. She would get results, the American Red Cross would guarantee the bill, they would send for the woman, the problem solved.

Shortly after that (several hours after the first telephone call), there was heard the screaming of sirens outside Dr. S.'s office, but he was pretty busy just then, could not look to see what was happening. The Red Cross worker came in as he entered his outer office. "We have come for the patient," she said. "Sorry," Dr. S. replied in a very tired voice, "You're too late. Mrs. R. has delivered a fine boy."

Unfortunately the Children's Bureau does not provide for rendering obstetric-pediatric services for servicemen's wives in doctors' offices.

SOCIAL MEDICINE TOPIC DISCUSSED

The trend in centralization of government as it affects the future of medical practice in this country was the subject of a talk given by Floyd E. Armstrong, professor of economics at Massachusetts Institute of Technology, last night at the first session of the People's university, sponsored in Battle Creek as a part of the public evening school program.

"When people ask for socialized medicine they are seeking, first, better medicine, then better medical service, lastly more rapid treatment. In other words they are seeking the best in medicine. Does the Murray-Wagner-Dingell bill, which proposes to make the medical profession one of the bureaus of this already too powerful bureaucracy, provide for this?

"The bill proposes to raise annually, through payroll deductions, approximately $12,000,000,000. This would mean that every employe in America would pay six per cent of his salary into an enlarged social security fund and this would be matched by another six per cent from the employer. It further proposes placing in the hands of one man—the Surgeon General of the United States—the power and authority to hire and appoint doctors, fix salaries, determine the number of individuals for whom any physician may provide service and to assign physicians in cases where the chosen one's quota is filled."

When statistical evidence shows that our American medical practice is way out in front compared to those all over the world, why is there need for change?" the speaker asked. The medical profession itself is resisting the proposal not because it is unfavorable toward medical insurance, but because it believes the end sought can be accomplished in a better way than the bill suggests.

No doctor in this nation is unsympathetic to the idea that people should get the best medical care possible for as reasonable a cost as it can be given, nor is any doctor not in favor of medical insurance to protect the common person, Mr. Armstrong pointed out in explaining that the question is not "will we get what we want when we seek socialized medicine, but how shall we get benefits from it?"

"Where will our doctors stand in this new plan?" the professor asked, and then sought to explain that they would be somewhat at a standstill in their profession because "you cannot drive men to improve their skills and to become better surgeons when there is not that persuasive influence of self-interest behind them."

Appeals to People

In conclusion, the professor appealed to the people of the university to think "American" when the time comes for them to support or to reject this bill. "We want an America of freedom, of independence and of self-reliance, not an America which will tell us what to do. We cannot think devoid of our prejudices," he agreed, "but let us make certain we are not defeating our own efforts."—*Enquirer-News, Feb. 4, 1944.*

SOCIALIZED MEDICINE

The Wagner Bill will be considerably modified, but some of its worst features may become law unless it is seen in its true light. *It is part of a program, now well advanced, to enslave the individual to the state. In this process, he gradually loses his adult self-reliance, lapses toward infancy, and then degenerates into a willing slave of government. It is the process by which strong nations sink toward extinction.*—Editorial, *The Indianapolis News,* August 9, 1943.

It must be remembered that the indigent are not covered by compulsory health insurance. The Wagner-Murray-Dingell Bill still leaves the really big problem unsettled.

Michigan State Medical Society

Second Annual

POSTGRADUATE INDUSTRIAL MEDICAL AND SURGICAL CONFERENCE

Thursday, April 6, 1944

Horace H. Rackham Educational Memorial

Corner Farnsworth—at Woodward

DETROIT, MICHIGAN

Sponsored by

The Committee on Industrial Health
Michigan State Medical Society
and the
Michigan Association of Industrial Physicians and Surgeons

in coöperation with

The Department of Postgraduate Medical Education
University of Michigan
and the
Wayne University College of Medicine



Samuel Peck, M.D.



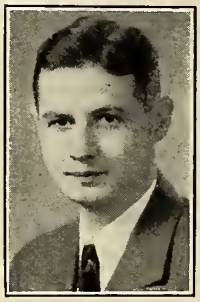
C. F. Long, M.D.



M. H. Solworth, M.D.



L. E. Himler, M.D.



C. A. Moyer, M.D.



Marion Jocz, M.D.



M. H. Pike, M.D.



J. W. Hirshfeld, M.D.

Program

General Chairman

Kenneth E. Markuson, M.D., Lansing
Chairman, Committee on Industrial Health
Michigan State Medical Society

MORNING SESSION

Presiding Chairman

Edgar H. Norris, M.D., Detroit
Dean, Wayne University College of Medicine

A.M.

10:00 Address of Welcome

C. R. Keyport, M.D., Grayling
President, Michigan State Medical Society

10:10 "Newer Trends in Industrial Sanitation."

Mohe H. Solworth, Louisville, Ky.
Sanitation Consultant

10:40 "The Psychiatric Approach to Current Mental Health Problems in Industry."

Leonard E. Himler, M.D., Ann Arbor
Consultant in Psychiatry, Detroit Transmission Division, General Motors Corp.

11:10 "How to Control Epidemics of Occupational Dermatitis with Special Emphasis on the Epidermophytoses."

Samuel Peck, Senior Surgeon (R), USPHS, Bethesda, Md.

11:40 "Criteria for Employability of Individuals with Lung Pathology."

Charles-Francis Long, M.D., Philadelphia
Chairman, Commission on Industrial Health and Hygiene, Medical Society of the State of Pennsylvania

LUNCHEON SESSION

Due to food rationing, no luncheon session has been arranged. Conferees may obtain luncheon at several good restaurants convenient to the Rackham Memorial.

AFTERNOON SESSION

Presiding Chairman

Albert C. Furstenberg, M. D., Ann Arbor
Dean, Medical School, University of Michigan

P.M.

2:30 "In-Plant Rehabilitation Programs for Disabled Veterans."

Marion Jocz, M.D., Detroit. Physician-in-charge, Diagnostic Division, Chrysler Corporation.

3:00 "Eye Pathology due to Exposure to Organic Solvents."

Melvin H. Pike, M.D., Midland, Consultant in Ophthalmology, Dow Chemical Company.

3:30 "A Comparison of Various Salt Solutions in the Treatment of Burns."

Carl A. Moyer, M.D., Ann Arbor
Asst. Professor of Surgery, University of Michigan.

4:00 "Clinical Uses of Penicillin."

John Winslow Hirshfeld, M.D., Detroit
Asst. Professor of Surgery, Wayne University College of Medicine.

Exhibit on "Cutting Oil Dermatitis"

Arranged through courtesy of Committee on Scientific Exhibit of

American Medical Association

Thos. G. Hull, Ph. D., Director

MICHIGAN'S DEPARTMENT OF HEALTH

H. ALLEN MOYER, M.D., Commissioner, Lansing, Michigan

X-RAY UNIT WILL VISIT FOUR STATE COLLEGES

Chest x-rays of all students enrolled in Michigan's four colleges of education will be secured with the opening of the fall term this year when the state health department's mobile photographic unit visits campuses in Mt. Pleasant, Marquette, Ypsilanti and Kalamazoo.

Approval of the x-ray program has been given by the state board of education.

Members of faculties of the four schools may avail themselves of the opportunity to secure x-ray examinations.

ACCIDENTS COST FEWER LIVES IN STATE IN 1943

Accidental deaths from all causes occurring in Michigan in 1943 dropped seven per cent from the 1942 total, according to unofficial figures supplied by the state health department. The 1943 total was 3,434, for the preceding year 3,685.

Deaths from automobile accidents dropped to 995 from the 1,370 recorded in 1942. Deaths from home accidents increased from 1,309 in 1942 to 1,391 in 1943. A 19 per cent increase in deaths of children under fourteen years resulted from accidents in the home, according to eleven-month figures.

There was a 10 per cent drop in deaths resulting from accidents in Michigan manufacturing plants during 1943 as compared with the 1942 total, with eighty-five deaths reported last year as against ninety-four in 1942.

Deaths from occupational accidents in all classifications totaled 314, a decline of 14 per cent from the 1942 total of 366. Greatest increase in occupational deaths was reported for the war-stimulated mining and quarrying industries, the thirty-eight deaths reported in this classification being exactly twice the number recorded for the preceding year.

SANATORIA HEADS PLAN CLOSER CO-OPERATION

Heads of Michigan's tuberculosis sanatoria will work even more closely in future with state health authorities in determining matters of institutional policy. An advisory committee of five members representing the Michigan Sanatorium Association will meet at least twice annually hereafter with physicians of the bureau of tuberculosis control of the Michigan Department of Health to discuss present and postwar problems. The committee represents Michigan's state, county, municipal and certain privately-operated sanatoria.

Members of the committee are: Dr. Paul T. Chapman, director of tuberculosis hospitalization and field service of the Herman Kiefer hospital, Detroit, chairman; Dr. John Barnwell, director of the tuberculosis division of the University of Michigan hospital; Dr. W. B. Howes, director of the Detroit Tuberculosis Sanatorium; Dr. E. W. LaBoe, superintendent of the Michigan State Sanatorium at Howell, and Dr. Charles R. Smith, superintendent of the Copper Country Sanatorium at Houghton.

Newly-elected officers of the Michigan Sanatorium Association are Dr. Henry Stuart Willis, superintendent of the Wm. E. Maybury sanatorium at Northville, president; and Dr. Joseph Egle, superintendent of the Northern Michigan sanatorium, Gaylord, secretary.

STATE LABS TO HANDLE PARATYPHOID CULTURES

State health department laboratories in Lansing, beginning February 1, were ready to aid Michigan physicians in identifying some of the rarer types of paratyphoid fever. The state laboratories are the sixth in the United States where such identification can be made.

Heretofore, cultures have been sent by the department to laboratories of the University of Kentucky, first in the United States to undertake such studies. Other laboratories where types of organisms causing paratyphoid can be determined are maintained by New York and Connecticut state health departments, Beth Israel hospital in New York City, and a California institution.

First typing station for the identification of such organisms was maintained in Copenhagen by the League of Nations. It is now in German hands.

DEMAND IS DECREASING FOR RECORDS OF BIRTHS

A 57 per cent drop last year in number of requests for assistance in establishing proofs of age and citizenship as compared with the record-breaking demand in 1942 is reported by the state health department. Industrial and Selective Service demands for proofs of identity fell off in the second year of war.

The department made 51,719 searches of records last year as compared with 121,328 searches in 1942, issuing 34,549 certified copies of birth records and 19,996 certifications, not including certified copies.

The department is custodian of records of births dating from 1867.

TUBERCULOSIS CLAIMS FEWER LIVES IN 1943

Fewer persons died of tuberculosis in Michigan in 1943 than during the preceding year according to unofficial state health department figures. Tuberculosis deaths, last year, totaled 1,781, or forty-six fewer than the 1,827 total of 1942. Average of deaths from this cause during the last five years is 1,810.

Male deaths, last year, totaled 1,136; female 645. Deaths among members of white races totaled 1,355, Negro 406, others twenty.

Tuberculosis caused most deaths from this cause in Detroit last year, as was the case also in 1942, Detroit's total of 904 exceeding by twenty-seven those

reported elsewhere in the state. Detroit's 974 tuberculosis deaths in 1942 exceeded the out-state total by 121.

Deaths resulting from tuberculosis among Detroit Negroes were 315 or 34.8 per cent of the total for that city, although Negroes constitute only 9.2 per cent of Detroit's population according to 1940 census figures.

MINOR CHANGES VOTED IN CONTROL MEASURES

The State Council of Health at its January meeting in Ann Arbor rescinded its resolution of July, 1942, prohibiting the rental of footgear by bowling alleys, skating rinks and similar amusement places. The Council also rescinded the requirement that bodies of persons who die of certain highly communicable diseases shall be shipped only in hermetically sealed metal containers, an action taken because of the wartime shortages of metals. Except for the above changes, 1943 regulations for the control of communicable diseases will remain in effect in 1944.

TOLL IN MOTOR TRAFFIC IS LOWEST SINCE 1924

Deaths resulting from automobile accidents in Michigan in 1943 will not exceed 975, according to a state health department estimate. It was the first time since 1924 that the annual traffic toll has dropped below the 1,000 mark.

The estimate represents a 28 per cent decline from the 1,351 total of 1942.

Deaths in the first 11 months of 1943 totaled 872, most fatalities occurring in September (106) and October (125). This is in keeping with the usual increase in motor vehicle deaths in fall months.

Five-year average of motor vehicle deaths (1938-1942) was 1,653.



THE INTERNATIONAL RED CROSS AND THE MEDICAL PROFESSION

The activities of the International Red Cross exert a powerful force toward the amelioration of the effects of war and represents an extension of the endeavors of the medical profession throughout its long history, *The Journal of the American Medical Association* points out in a recent editorial reviewing its history and functions. *The Journal* says:

"The International Red Cross was born of war and still serves most actively in wartime. The International or Geneva Red Cross movement rests on the foundation of the individual national organizations even though these vary widely in structure and importance in different countries. Since 1928 the International Red Cross has been a three-headed organization which includes the national societies of the Red Cross, the International Committee and the League of the Societies of the Red Cross.

"During the war of 1870 the International Committee assumed for the first time the assistance to prisoners of war and created an agency for prisoners at Basle. Later this agency was removed to Geneva. Past experiences were reviewed in 1929; this resulted in the adoption of the revised convention of Geneva in that year regarding the treatment of prisoners of war. This convention was ratified by most countries except Finland, Japan, Russia, and certain countries of Latin America.

"The principal features of this code relate to the visiting of camps for prisoners of war by delegates of the International Committee. The official delegates may consult with trusted prisoners ('hommes de confiance') who have been selected by their comrades and who represent them. These visits to camps make it possible for the delegates of the committee to request the camp authorities for improvements; they allow for the intervention of the International Committee itself. By reciprocity these visits permit equal improvements to be made in the conditions of prisoners of war held by the other side.

"The Central Agency for Prisoners in Geneva is concerned not only with prisoners of war but with all categories of war victims including wounded and sick, civilian internees, military internees in neutral countries, refugees in their own countries and civilians separated from their families by hostilities. This agency is consequently a vast organization with four big buildings in Geneva and 3,500 workers; it has received over 19 million letters and telegrams and has dispatched some 20 million. Some 60 thousand letters are received by this agency each day.

"A monthly journal in French records much of the current work of the International Red Cross. Of particular interest to Americans are the reports of visits to military prison camps and civilian internees in Japan proper and in such places as Shanghai and Hong Kong. Japan, although not a signatory of the Geneva Convention, previously indicated its intention of complying with its provisions. In most camps visited, conditions for both military personnel and civilians appear to be satisfactory. One recent report concerning the Stanley Camp for interned civilians at Hong Kong makes the somewhat enigmatic statement that the composition of rations has been recently improved. Reports on Japanese camps for Chinese and vice versa and on Russian camps for Axis prisoners and the reverse are missing.

"Altogether the International Red Cross exerts a powerful force toward the amelioration of the effects of war and represents an extension of the endeavors of the medical profession throughout its long history."

Woman's Auxiliary

WORK, WORK, WORK!

The officers of the Woman's Auxiliary to the Michigan State Medical Society are most appreciative of the invitation of the Medical Society, extended to them and the County Presidents, to attend "The School of Information" held January 30 in Detroit.



Mrs. J. J. Walch, *President*

The most effective expression of our realization of the importance of this combined meeting was demonstrated in our active participation in the plans and suggestions of our County Medical Societies. Each county is now provided with information and has been instructed how to use it. This work is dependent upon the continued effort of each individual member.

Your officers ask you to become thoroughly informed about the legislation and trends toward medical regimentation, and then to *work, work, work.* Let us respond wholeheartedly to the Medical Society's request for assistance.

MARY NEE WALCH

SAGINAW COUNTY

The Saginaw County Medical Auxiliary was honored at its November meeting by the presence of the State Auxiliary President, Mrs. John J. Walch. The Bay City Auxiliary was invited to the meeting. The December meeting was a dinner with the doctors. A social meeting was held in January, and members sewed for The Children's Home.

* * *

Subscribe to the Bulletin

* * *

KENT COUNTY

The Auxiliary to the Kent County Medical Society has had several interesting meetings. The first meeting of the year was a luncheon at the Browning Hotel, Grand Rapids, on October 1, when a war movie, "Target for Tonight," was shown.

On November 10, members met for luncheon at the Browning Hotel, and enjoyed Mrs. Fred C. Brace's review of Paul De Kruif's book, "Kaiser Wakes the Doctors." Wm. J. Burns, Executive Secretary, Michigan State Medical Society, spoke on the "Wagner-Murray-Dingell Political Medicine Bill."

Mrs. Ward S. Ferguson, president, has the following chairmen to assist her: *Program*—Mrs. Guy W. DeBoer and Mrs. Martin Batts; *Membership*—Mrs. Gerrit E. Winter; *Courtesy*—Mrs. W. D. Lyman; *Historian*—Mrs. Henry P. Kooistra; *Social*—Mrs. James C. Droste; *Revision*—Mrs. Henry J. Pyle; *Legislature*—Mrs. William A. Hyland; *Philanthropic and Welfare*—Mrs. J. D. Miller; *House*—Mrs. Burton R. Corbus and Mrs. John T. Hodgen; *Nutrition*—Mrs. William L. Rodgers; *Public Relations*—Mrs. E. H. Fuller; *Medical and Surgical Relief*—Mrs. Robert H. Denham; *Hygeia and Bulletin*—Mrs. J. D. Miller; *Press and Year Book*—Mrs. Henry P. Kooistra and Mrs. Floyd J. Gibbs.

* * *

"It would be most desirable to know the ultimate cost of compulsory social security. If it is not going to cost too much, say not more than $2,000,000,000 a year, why should we be upset about it? But, if it is going to cost a very large amount, say $20,000,000,000 a year, then there is good reason for some very serious thinking. Such an amount could hardly be raised without greatly disturbing the normal wealth-creating functions of the national economy. In this event, we should spare no effort to find out more about the cost of compulsory social security. High or low, it would be desirable to know.

"The sad fact of the matter, however, is that no one knows. Not even the Federal Government, which has given more time and money to the study of social security than any other person or organization, knows what its cost will be." —GERHARD HIRSCHFELD.

CLASSIFIED ADVERTISING

PHYSICIAN WANTED—Full time. To be director of the Lansing Department of Health Venereal Disease clinic. Position immediately available. Salary $4,200. Contact Floyd R. Town, M.D., Lansing Dept. of Health, 207 City Hall, Lansing 7, Michigan.

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Chemists to the Medical Profession MIC 3-44

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A W O L

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But for so many, absenteeism is motivated solely by a desire to avoid the risk of physical distress and emotional uncertainty, caused by vulval irritation from perineal pads . . . or by fear of olfactory offense . . . or conspicuous bulging under slacks or coveralls.

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They have found that Tampax is free from the prospect of vulvovaginal irritation. It cannot cause noticeable bulkiness, or expose the flux to odorous decomposition. Its three absorbencies permit selection, to meet personal daily needs, amply and safely.

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COUNTY AND PERSONAL ACTIVITIES

The Wagner-Murray-Dingell Bills (S. 1161 and H.R. 2861) contain no provision for the care of indigents!

* * *

"There is nothing as irresistible as a thought whose time has come"—Floyd E. Armstrong, M.D., Professor of Economics, M.I.T.

* * *

The Mississippi Valley Medical Society will hold its tenth Annual Meeting in Peoria, Illinois, September 27-28, 1944.

* * *

Parker Heath, M.D., Detroit, is the author of an original article "Chemotherapy in Ophthalmology" which appeared in the JAMA of January 15, 1944.

* * *

"I don't believe that the Creator put us on this earth to obtain security without effort"—Floyd E. Armstrong, M.D., Professor of Economics, M.I.T.

* * *

"A panel system is an excellent thing for the dud doctor. Unfortunately, a good doctor will be a good doctor under any system."

* * *

Wilfrid Haughey, M.D., Editor of The Journal of the Michigan State Medical Society, spoke before the Jonesville Lions Club on February 21 on the "Wagner-Murray-Dingell Bill."

* * *

Roy D. McClure, M.D., and the Surgical Staff of Henry Ford Hospital, Detroit, entertained the members of the Flint Academy of Surgery to a Scientific Meeting, Luncheon and Surgical Clinic on January 12, 1944.

* * *

J. Earl McIntyre, M.D., Lansing, Secretary of the Michigan Board of Registration in Medicine, was guest speaker at the annual meeting of the Federation of State Medical Boards, held in Chicago, February 15. Doctor McIntyre discussed "Medical Licensure Aspects."

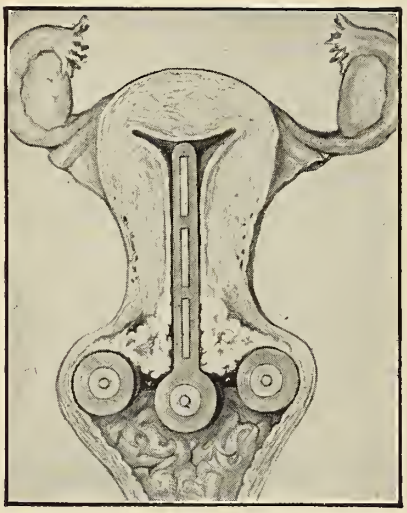
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The Seventh Annual Postgraduate Course in Ocular Surgery, Pathology and Orthoptics, sponsored by the George Washington University School of Medicine, Washington, D. C., will be held April 24 to 29, inclusive. For further information apply to the Secretary, 927 Seventeenth Street, N. W., Washington, D. C.

* * *

E. R. Witwer, M.D., Councilor of the 16th District of the Michigan State Medical Society and Secretary of the Wayne County Medical Society, has been elected

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Congratulations, Councilor Witwer!

* * *

"The Wagner-Murray-Dingell Bill would put the practice of medicine on the assembly line," stated Doctor F. J. Cullen, Executive Vice President of the Proprietary Association of America at a recent meeting of the Scientific Section held in New York City. "If this bill passes, patients will be treated in the future by assembly-line methods."

* * *

The American Physicians' Art Association will hold its 7th Annual Exhibit at the AMA meeting, Chicago, June 12-16. The Art Gallery will be in the main Ballroom Balcony of the Stevens Hotel, Chicago. Mead Johnson and Company of Evansville, Indiana, is underwriting the cost of the exhibition. Entry blanks may be obtained by writing Francis H. Redewill, M.D., Secretary, Flood Building, San Francisco.

* * *

The Michigan Basic Science Board reports that since it was created in 1937, it has given 776 examinations, of which number 567 have passed and 209 have failed in one or more subjects. The Board has granted thirty-three certificates by reciprocity, of which number sixteen were certified to the Osteopathic Board, seven to the Medical Board, seven to the Chiropractic Board, and three did not indicate to what profession they belong.

* * *

Michigan medical men on the program of the Sixth Annual Congress on Industrial Health, sponsored by The Council on Industrial Health, American Medical Association, held in Chicago, February 15-16, were: Edgar H. Norris, M.D., Clarence D. Selby, M.D., Roy D. McClure, M.D., Conrad Lam, M.D., all of Detroit, Frank F. Tallman, M.D., Lansing, and Max Burnell, M.D., Flint.

* * *

The Public Debt.—By June 30, 1944, the public debt will reach about $198 billion and a year later $258 billion, and soon it will be necessary to request legislation authorizing a further increase in the debt limit from the present $210 billion level. Our debt policy has maintained low and stable interest rates, now less than 2 per cent on the average. A debt of $258 billion will require gross interest payments of $5 billion annually at present rates. With a national income of $125 billion or more, these payments need not prove oppressive.

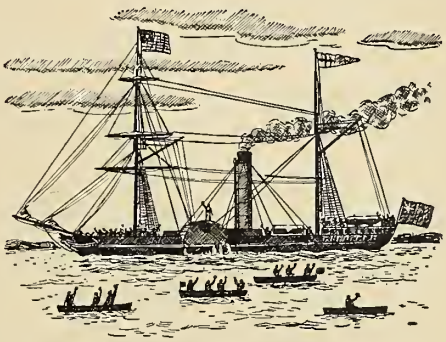
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"Urology Award.—The American Urological Association offers an annual award 'not to exceed $500' for an essay (or essays) on the result of some specific clinical or laboratory research in Urology.

"The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, June 19-June 22, 1944, Hotel Jefferson, St. Louis, Missouri.

"Essays must be in the hands of the Secretary,

The Ship is different today...

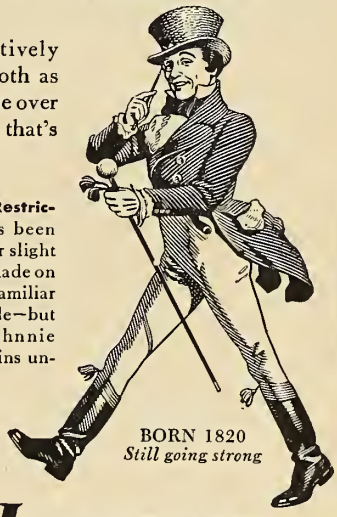


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* * *

Cost of the E.M.I.C. Project! In less than seven months, the Federal Emergency Maternal and Child Health Program for Servicemen's Wives jumped from an appropriation of $1,200,000 to one of $18,620,000.

The Children's Bureau allotment and Congressional appropriations have been as follows:

1.	Prior to March 18, 1943, U. S. Children's Bureau allotments	$ 390,177.00
2.	Public Law 11, March 18, 1943	1,200,000.00
3.	Public Law 135, July 12, 1943	4,400,000.00
4.	Public Law 156, October 1, 1943	18,620,000.00
	TOTAL	$24,610,177.00

* * *

Two Narcotic Licenses Necessary—June 30 is the deadline for both the state and federal narcotic licenses. Shortly physicians will receive from the federal government Form No. 678 which now carries a special location in which the physician's state narcotic license number must be listed. This means that the state narcotic permit must be received first. The state does not send out forms. It is necessary for a physician to write to Mr. F. A. Taft, Director of Drugs and Drug Stores, Lansing, Michigan, enclosing $1.00 and requesting the certificate. The federal fee is also $1.00.

* * *

Enrollment of physicians in Michigan Hospital Service.—The annual enrollment period in Michigan Hospital Service will be during the month of March. A letter and application form will be sent to all members of the Michigan State Medical Society who are not enrolled in the plan at the present time. If you are interested in obtaining this protection, please complete the application form and return it to the offices of Michigan Hospital Service not later than April 1, 1944. Protection for new applicants will become effective on May 1, 1944. The next opportunity to enroll will be April, 1945.

* * *

The programs of the Michigan Society of Neurology and Psychiatry for the present year have all been related to the present military emergency. At the meeting held on September 23, 1943, John C. Whitehorn, M.D., Professor of Psychiatry at the Johns Hopkins University School of Medicine, Baltimore, Maryland, addressed the Society on "Individual Issues in Post-Military Psychotherapy." On November 30, 1943, the Hon. Walter S. Maclay, Medical Superintendent of the Mill Hill Emergency Hospital, London, England, spoke on "Neurotic Disabilities in a Total War: The Rehabilitation of Neurosis Cases" and showed a film of the work being carried on at the Mill Hill Hospital. On January 20, 1944, Raymond W. Waggoner, M.D., Professor of Psychiatry at the University of Michigan Medical School, spoke on "Selection, Rejection, Rehabilitation: Our Psychiatric Responsibilities." The March meeting of the Society will be devoted to a consideration of the problem of juvenile delinquency.

Say you saw it in the Journal of the Michigan State Medical Society

SHOWDOWN ON DICTATORSHIPS BY BUREAU APPROACHING

We'll wager even money right now that it won't be long until the masters of strategy within the U. S. Children's Bureau will come forth with a recommendation (that is what they call it but some like to term it "directive") that the states revise their present programs of emergency maternity and infant care for the wives and children of servicemen to include general medical and surgical care for servicemen's wives—at least partial coverage. And, we'll lay another bet that there will be no provision to handle this on a cash allotment basis.

That's another step toward Federalized medicine, you say! Of course. Just a few more steps and Senator Wagner can junk his bill. It won't be needed by him to accomplish his purpose, as others will have done the job for him.

The wife of any serviceman who needs medical or surgical care deserves the best professional services available. If she cannot afford such care, it is the obligation of the government or some responsible private agency to provide the funds. These points are taken for granted.

But, how long are Congress and the people going to let the Children's Bureau act as the supreme dictator on such matters? If we are going to have a general Federal medical program, is Congress going to say what it shall be, or is the present policy of permitting a bureau of political appointees to draw the blueprint and administer it going to be continued indefinitely? Is the medical profession of this country going to have an opportunity to offer suggestions and to criticize, or is it going to have more and more programs shoved down its throat, and told to like them or lump 'em? How long is "for the duration"? How soon are we going to get back to applying the yardstick of need to decide who shall or shall not be entitled to public funds or the services provided at public expense? If a Federalized medical program is needed for the wives of servicemen, will one be needed for the servicemen themselves when suffering from nonservice-connected disabilities? Is some bureau going to decide that and write the ticket, or will Congress be the judge and author of the plan?

Looks as if there might be troublesome times ahead, doesn't it? How would you react and what would you do if you were a member of The Council of the Ohio State Medical Association and had these problems dumped into your lap?—*Ohio State Medical Journal*, January, 1944.

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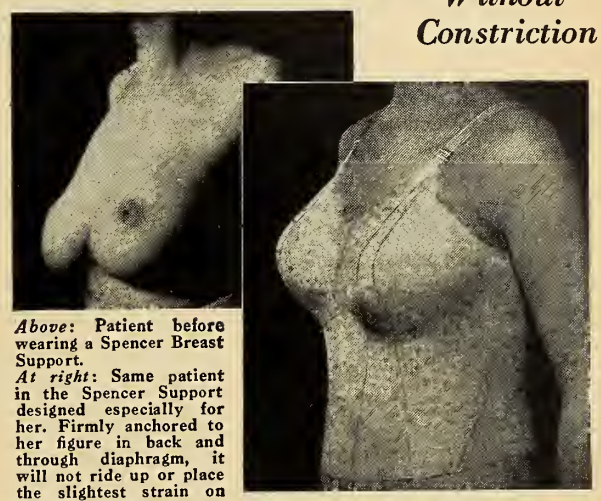
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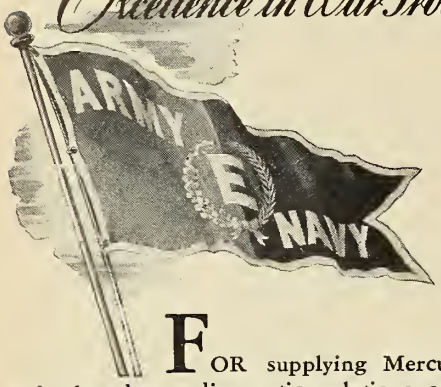
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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

PSYCHOLOGICAL MEDICINE. A short Introduction to Psychiatry, with an Appendix, War Time Psychiatry. By Desmond Curran, M.D., F.R.C.P., D.P.M., Psychiatrist and Lecturer in Psychological Medicine, St. George's Hospital, and Honorary Psychologist to the Maida Vale Hospital for Nervous Diseases, Temporary Surgeon Captain R.N.V.R., and Eric Guttmann, M.D., L.R.C.P. Ed. Neuropsychiatric Specialist Emergency Medical Service, etc. Foreword by J. J. Conybeare, D.M. (Oxon.), F.R.C.P. Physician to Guy's Hospital. A William Wood Book. Baltimore: The Williams and Wilkins Company. 1943. $3.50.

"Three years of war have brought psychiatry to the front . . . After the first world war many of the disorders and hysterical reactions were attributed to such organic conditions as shell shock, or other experiences, but now it is realized that the pathogenesis of these conditions is mainly psychological, and that the symptom complexes were not infrequently the result of ill-judged medical advice." This book is an attempt to analyze and study these mental and other stresses, to recognize the unstable recruit and avoid the breaking point which many of them would not have reached in the ordinary way of life. Psychiatric case taking is especially stressed, with a study of affective reactions types, hysterical reactions, drug neuroses, and management and treatment. It is a small but very helpful book.

ELEMENTS OF MEDICAL MYCOLOGY. By Jacob Hyams Schwartz, M.D., Assistant Professor of Dermatology, Harvard Medical School and Postgraduate School, Member American Dermatological Association, American Mycological Association, Dermatologist Massachusetts General Hospital. Introduction by Fred D. Weidman, M.D., Professor of Dermatological Research, University of Pennsylvania. New York: Grune & Stratton, 1943. $4.50.

The field of Mycology has been rather neglected and is ripe for this new book which approaches the study of mycology in a different way, stressing the infective organism, and its complete study together with the medical aspects. There are seventy-eight fine illustrations, an outline of the origin and morphology of the fungi and a table giving the pathological fungi, showing the organism, the clinical picture and the mycological findings, with pen illustrations. Many formulæ are given for the treatment of these diseases. The book is well printed on excellent paper and in large easily readable type, and good style.

THE COMPLEAT PEDIATRICIAN. Practical, Diagnostic, Therapeutic and Preventive Pediatrics, for the use of Medical Students, Interns, General Practitioners, and Pediatricians. Fourth edition. Wilburt C. Davison, M.A., D.Sc., M.D., Professor of Pediatrics, Duke University School of Medicine, and Pediatrician Duke Hospital. Durham, N. C.: Duke University Press, 1943. $3.75 (by check); $4.00 (credit).

The whole field of pediatrics is covered in the form of an encyclopedia. The subject is divided into systems such as gastro-intestinal, skin and contagious, neuropsychiatric, circulatory, orthopedic, etc., but under these headings individaul subjects are discussed, such as Acrodynia, Ataxia, Agranulocytosis, Malformations

(Continued on Page 266)

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THE ARTHROPATHIES. A Handbook of Roentgen Diagnosis. By Alfred A. de Lorimier, A.B., M.A., M.D., Colonel, Medical Corps, United States Army, Commandant The Army School of Roentgenology, Memphis, Tenn., formerly Director Department of Roentgenology, The Army Medical School, Washington, D. C. Chicago. The Year Book Publishers, Inc., 1943. $5.50.

Col. de Lorimier has used the great store of information he and his colleagues have acquired during years of teaching, and has made it available in this most useful volume. There are 678 illustrations, all x-rays of some part or whole joint giving the points to be studied in disagnosing. This is accompanied by sufficient description to make the facts useful to the doctors who are caring for these patients having arthropathies, which constitute the third largest group requiring hospitalization and compensation since the last war, and now constitute the fifth largest group requiring such care and pension.

This book will not make a rentgenologist out of the doctor who uses it, but it will help him greatly in diagnosing his cases. We have never seen a group of x-rays that seemed to give more vivid illustrations of the pathology.

PAIN. Proceedings of the Association for Research in Nervous and Mental Disease, December 18 and 19, 1942 at New York. With 116 illustrations and 19 tables. Baltimore: The Williams and Wilkins Company, 1943. Price $7.50.

This is Volume XXIII of the research publications of this society, and is an extremely interesting work. Pain is studied, measured, and its causes are determined experimentally. For the intensive student of medicine this is a gold mine. The receptive mechanism is described, also the pain-producing impulses in peripheral nerves. A case of insensitivity to pain is reported in detail, with comments and discussion. The nature of itching gets a chapter. There are many studies on producing pain by various methods, as cold, visceral reactions, muscle contractions. Headache mechanisms due to stimuli, pressure, et cetera, are studied. There is a chapter on pain traceable to nasal and paranasal stimuli, reporting many and various actual experiments. The same study is made of pain traceable to the eye and its adnexia. Many pains are due to scalp and neck muscles. Cardiac pain gets three chapters. There are chapters on the relief of pain by rhizotomy, and the relief of head pains by surgical methods. We are intrigued by this book.

FRACTURES AND DISLOCATIONS FOR PRACTITIONERS. By Edwin O. Geckeler, M.D., F.A.C.S., Fellow of the American Academy of Orthopaedic Surgeons, Diplomate of the American Board of Orthopaedic Surgery. Third edition. A William Woods Book. Baltimore: The Williams and Wilkins Company, 1943. $4.50.

With the war and the increased amount of industrial work there has been a great increase in trau-

matic surgery, and books are necessary to keep the practitioner who must do a great bulk of this work up to date. The fundamentals of treatment are emphasized. The reasons for good and bad results are detailed. The best accepted methods are described and illustrated. The use of plaster, the use of traction, and occupational therapy all are well taught. It is a fine book and will be most valuable to the practitioner.

PATHOLOGY AND THERAPY OF RHEUMATIC FEVER. By Leopold Lichtwitz, M.D., lately Chief of the Medical Division of the Montefiore Hospital, and Clinical Professor of Medicine, Columbia University, New York City. Foreword by William J. Maloney, M.D., LL.D., F.R.S. (Edin.) Consulting Neurologist to the City Hospital, Formerly Professor of Nervous and Mental Diseases Fordham University. Edited by Major William Chester, M.C. New York: Grune and Stratton, 1944. Price $4.75.

Professor Lichtwitz says, "The pathologic basis of this disease is the allergic sensitization of certain mesenchymatous tissues." He wrote this book defending this concept. He claims that "rheumatic fever is a disease not of invasion but of defense. . . . It is not caused by a specific microörganism or virus, but by a sensitization to antigens, protein in nature, which in most instances are products of microörganisms. . . . Rheumatic fever in the majority of cases is a secondary disease. Preceding it there is usually a mild infection of the upper respiratory tract, such as a sore throat or tonsillitis." Proper discussion is given to the definition, general pathology, rheumatic heart disease, vascular disease, arthritismyositis and manifestations in the skin, nervous system and other organs and areas. Under therapy he discusses prevention, general therapy and antirheumatic drugs. He says "the tonsillectomy vogue is fortunately waning," he refers to Aycock's report that tonsillectomy makes children more susceptible to poliomyelitis. He has a treatment to cure tonsils "whose crypts are swollen with putrid, necrotic matter." He claims the mass of cases which prove the case for tonsillectomy can be equalled by a similar mass of cases proving the opposite. Despite the author's case against tonsillectomy we think the book is a challenge and well worth reading. He has made out a case for his theory of allergy. "Infectious foci on the one hand and rheumatic fever and chronic arthritis on the other are so common that chance inevitably brings them together."

A TEXTBOOK OF MEDICINE. Edited by Russell L. Cecil, A.B., M.D., Sc.D., Professor of Clinical Medicine, Cornell University Medical College; Attending Physician, New York Hospital; Visiting Physician, Bellevue Hospital, New York City. Associate Editor for Diseases of the Nervous System—Foster Kennedy, M.D., F.R.S.E., Professor of Cilnical Neurology, Cornell University Medical College; Attending Physician, New York Hospital; Visiting Physician in Charge, Neurological Service, Bellevue Hospital; Consulting Physician, New York Neurological Institute. Sixth Edition, revised and entirely reset. 1566 pages with 195 illustrations. Philadelphia and London: W. B. Saunders Company, 1943. Price $9.50.

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shelf; however, the new Sixth Edition contains many features which are worth noting.

The new edition contains changes both in text and format. There are several new contributors as well as many new topics which were not covered previously. Among the new additions are chapters on Virus Pneumonia, Aviation Medicine, Seasickness and Air Sickness, Pathologic Physiology of Circulatory Failure and Cardiac Pain and several others. In addition to these new chapters many new treatises have been written bringing the previous subject matter up to date.

Particular attention has been given to the section on Cardiovascular Diseases, of value is the list of normal laboratory values which is placed conveniently in the back of the book.

The change in format consists in a rearrangement of the text in double columns on a larger page. This lends itself to much easier reading.

It is the reviewer's opinion that the book comes as close as possible to being the ideal medical reference book for the busy practitioner.

CLINICAL LABORATORY METHODS AND DIAGNOSIS. By R. H. A. Gradwold, M.D., D.Sc. A textbook on laboratory procedures with their interpretation. Third edition. Two volumes, cloth bound, with 726 text illustrations in both volumes and 57 color plates. St. Louis: C. V. Mosby Company, 1943. Price $20.00.

This is a comprehensive treatise of clinical laboratory diagnosis with laboratory procedures. This is the third edition which has been revised, parts of it rewritten and much new material added which brings this publication up to date.

New photomicrographs, illustrations and color plates have been added; all are of good quality. Whenever possible, several methods are outlined for obtaining values giving the technician a choice of procedures depending upon the material and apparatus available. These volumes are intended primarily to serve as a guide or text to the laboratory technician; the books are, however, rather cumbersome to be conveniently used as a laboratory manual.

The author has endeavored to correlate the clinical symptomatology with the laboratory findings, which is so necessary for a clear understanding by the technician.

In the section on blood chemistry the principles and explanations underlying various tests and procedures are omitted. The photo-electric colorimeter has come into universal use in all modern clinical laboratories, yet no chemical procedures are submitted which could serve as a model for their application and use. Mention is merely made that the manufacturers will supply the instructions for each instrument.

The so-called "explanation of the hydrogenion concentration" is entirely inadequate and incomplete.

Hematology is covered satisfactorily; it is marred, however, by the part of this section devoted to the "Blood picture in various infectious diseases." "Typical hemograms" do not exist for many infectious diseases listed; notably among these is appendicitis. The author bases his conclusion in one instance on a series of only ninety-seven cases. The chapter on blood groups and

Say you saw it in the Journal of the Michigan State Medical Society

transfusions is a new and valuable addition. It includes information on the Rh factor, the M & N agglutinogens and subgroups of A.

Additions have been made to serological diagnosis; this permits further evaluation of tests by comparative study.

Toxicological technic and crime detection should not be undertaken by the clinical laboratory worker for the results of the examination always carry with it the medical legal aspect. The individual making these tests must therefore be able to qualify as an expert.

Three hundred and eighty-three pages are devoted to parasitology and tropical medicine. This section is profusely illustrated showing the characteristics and diagnostic features of the parasites and their ova. The diagrams of the life cycles of parasites should be most helpful to the student of this subject. This subject will undoubtedly assume more prominence with the return of the troops from widely separated sections of the world where they are exposed to various tropical and parasitic diseases.

This should be a valuable edition to the library of the clinical laboratory.

REACTION TO INJURY. By Wiley D. Forbus, M.D., Professor of Pathology, Duke University and Pathologist to the Duke Hospital. Pathology for students of disease based on the functional and morphological response of tissue to injurious agents. 532 illustrations, 20 in color. Baltimore: The Williams and Wilkins Company, 1943. Price $9.00.

This is a text for students of pathology. The author prefers to designate it, "Reaction to Injury." This is the



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first of two volumes; the second volume is in the process of preparation for publication.

This volume consists of two parts: "The introduction to the study of diseases" and "Resistive reaction to injury"; it deals exclusively with infectious diseases. The author develops his subject matter on broad principles rather than on detailed stereotyped style to which so many of the writers on this subject adhere. He treats this material as a live subject embodying a series of sequences which occur in disease, physiologically as well as anatomically. The subject matter is based on three fundamentals, by which the individual can react to disease; by resistance, by submitting and effecting an adaptation.

This book makes fascinating reading as it is more like a novel than what is usually considered a "dry" subject. The style is easy and simple, well arranged, devoid of the usual statistics and names of writers which have a tendency to interrupt the continuity of thought.

The illustrations and photomicrographs are largely original and on the whole of good quality yet the descriptive legends do not seem sufficient to point out the salient features to the uninitiated student, despite the author's opinion to the contrary.

The viral, rickettsial and fungus diseases have been given deservedly prominent space as have some of the tropical diseases. This has undoubtedly been motivated by the importance that these entities are assuming by the return of soldiers now serving in various parts of the world.

Every physician would do well to read this book and keep it as a handy reference.

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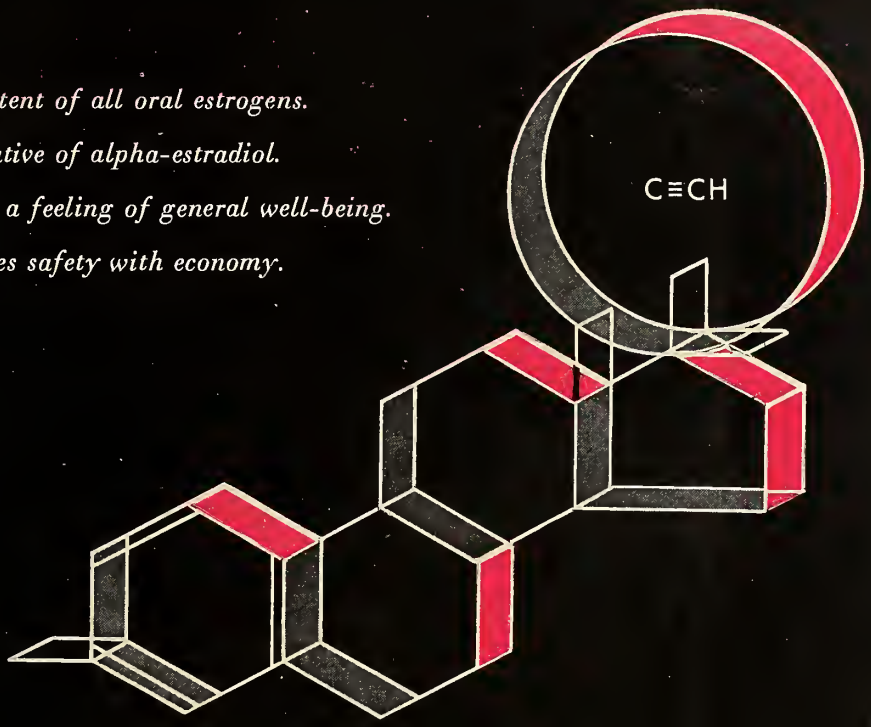
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REPORT ON SPECIAL SESSION OF THE MICHIGAN LEGISLATURE, 1944

The 62nd Michigan Legislature convened in extraordinary session on January 31 and adjourned February 18, 1944, accomplishing much of value in this short period of time. All the appropriations to run the state government for the fiscal year beginning July 1, 1944, were enacted as well as Governor Kelly's juvenile delinquency and aid to veterans program.

Sixty-two bills were introduced of which fifty-nine were passed by the Legislature.

Five Bills of Special Interest to Doctors

The medical profession was especially interested in five bills: HB 8; HB 9; SB 1; SB 9; SB 20.

1. *House Bill No. 8* called for an amendment with respect to the Probate Code concerning adoption procedure, investigation of proposed home by county agent or placement agency, supervision by county agent of adopted child during one-year period, and secrecy of adoption records. This bill was referred to the House Judiciary Committee which did not report it out.

2. *House Bill No. 9* proposed amendments to procedure in the Juvenile Division of Probate Courts. It rewrote the chapter and liberalized the powers of the probate judge in neglected and delinquent child cases. Section 18 (H), giving the probate court authority to provide a juvenile child with "medical, dental, surgical, or other health care, in a hospital or elsewhere" was so vague and broad that the Senate amended the section to read:

"Section 18 (H), Provide the child with such medical, dental, surgical, or other health care, in a local hospital if available or elsewhere, maintaining in so far as possible a local physician-patient relationship, and with clothing and such other incidental items, as the court seems necessary."

On the last day of the Session, The House concurred in this Senate amendment.

The Crippled-Afflicted Children Acts were specifically exempt from the provisions of this law. (Act No. 54 of P. A. 1944)

3. *Senate Bill No. 1* amended the election law to advance primary from September to July to facilitate veterans' voting, and amended other sections to conform. Provided for war ballots in conformity with federal law to be voted by armed service personnel including county, state, and legislative offices. (Act No. 4 of P. A. 1944)

4. *Senate Bill No. 9,* the appropriation measure for various public health purposes, as introduced would have set the state health commissioner's salary at $6,000. The Senate raised this to $9,000; the House lowered it to $7,500; the bill went to Conference Committee which on the last day of the Session recommended that the $9,000 salary set by the Senate be concurred in. The Conference Committee Report was approved by both the House and the Senate.

In this same bill, the appropriations for afflicted and crippled children's care were reduced to figures commensurate with the actual disbursements for the operation of these two Acts during the last biennium. (Act. No. 15 of P.A. 1944)

5. *Senate Bill No. 20* created a veterans' reserve fund of $1,000,000 and provided for disbursement by the State Administrative Board. Section 2 reads as follows:

"Said veterans' reserve fund shall be expended under the supervision and direction of the state administrative board to provide for the hospitalization, medical treatment, education and such emergency care and assistance as may be found necessary during the war period for the returning veterans of Michigan. Such appropriation shall be expended as provided in the accounting laws of the state." (Act No. 45 of P.A. 1944)

WILLIAM DeKLEINE, M.D.—MICHIGAN'S NEW COMMISSIONER OF HEALTH

William DeKleine, M.D., assumed office as Commissioner of Health of the State of Michigan on March 15, 1944.

Medical director of the American Red Cross from 1928 to September, 1941, and the man responsible for the introduction of the present Red Cross blood plasma program for the military forces, Dr. DeKleine has a broad background of experience in both private practice and public health work, as was pointed out by Governor Harry F. Kelly in his formal announcement of the appointment. The Governor said:

"In appointing Dr. DeKleine, I am giving the Michigan Department of Health a man whose broad background and fine record make him one of the country's outstanding public health authorities and who, through experience, is thoroughly familiar with the field of private medical practice.

"His alertness and initiative are demonstrated by his introduction of the blood plasma program for the armed forces and his promotion of the campaign to wipe out pellagra.

"It will be reassuring to have as head of our state health department in this all-important war year a man who is familiar with these and other progressive practices and who is well qualified to meet any health problem that may arise.

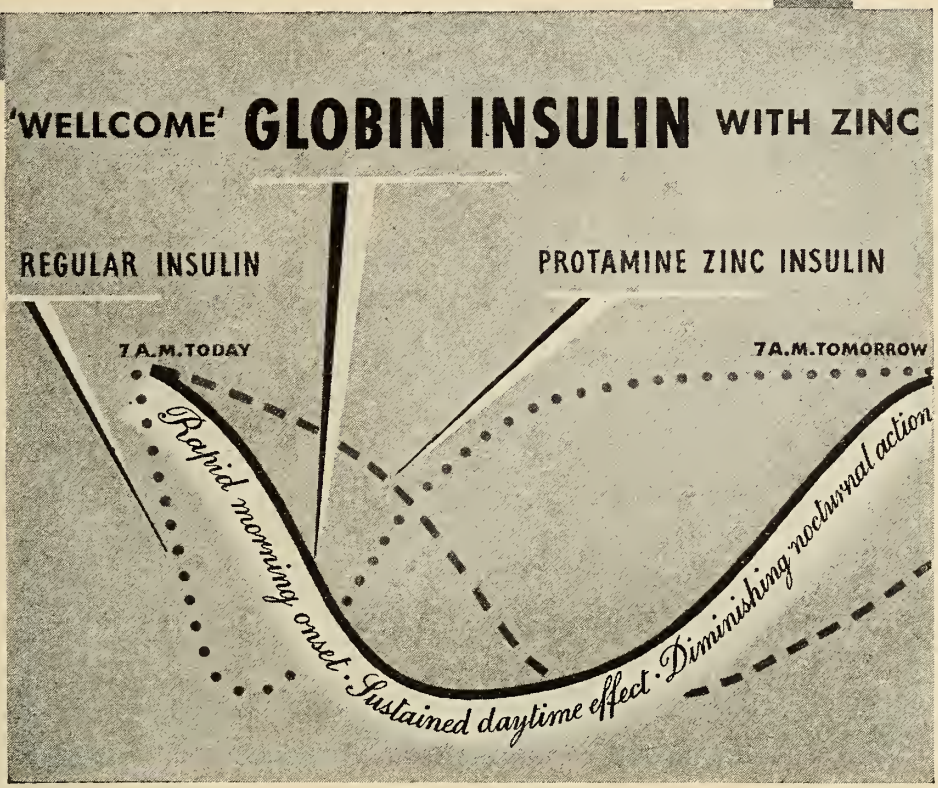
"A graduate of the Northwestern University Medical School and the Graduate School of the University of Michigan, Dr. DeKleine practiced medicine at Grand Haven, his home, from 1906 to 1914.

He was the first full-time health officer in Flint (1917-1922) and in Saginaw (1922-1927), organizing modern health departments in both cities.

"In 1927, he was loaned to the Red Cross to direct medical relief activities during the Mississippi flood and his permanent assignment as National Red Cross medical director came as a result of the record he established in this work. . . . Since retiring as Red Cross medical director in September, 1941, he has engaged in private practice in Washington, D. C.

"Dr. DeKleine is a former president of the Michigan Tuberculosis Association and the Michigan Public Health Association, and a former member of the boards of directors of the National Tuberculosis Association and the National Health Council. He is a fellow of the American Medical Association and the American Public Health Association; a member of the Medical Society of the District of Columbia and the Southern Medical Association."

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Wilner, Irvin A.
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Woolf, Martin P.
Work, Walter P.
Wright, Joseph W.
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Table of Contents

Dermatitis of Wartime Industries in General Practice.
H. R. Foerster, M.D. 307

Avitaminosis in Dermatology and the Value and Limitations of the Sulfa Group in Skin Diseases.
Oliver S. Ormsby, M.D. 315

Establishment of the First Public Health Laboratory in the United States.
Earl E. Kleinschmidt, M.D., Dr.P.H. 320

Protein Metabolism and Resistance to Infection.
Paul R. Cannon, M.D. 323

President's Page:
MSMS Committees 327

Annual Michigan Postgraduate Program for Graduates in Medicine 328

Editorial:
EMIC 329

Contributions to MSMS Foundation for Postgraduate Medical Education 329

Regimented Control 329

Plans for the Future 329

National Survey on Medical Services 330

Bar Association Condemns S1161 331

The Success of Michigan Medical Service 331

Correspondence 331

Annual Session of the Council MSMS (Concluded) 332

You and Your Business 341

Woman's Auxiliary 342

County and Personal Activities 343

The Doctor's Library 349

Report on Special Session of the Michigan Legislature, 1944 280

Michigan Doctors of Medicine in Military Service .. 282

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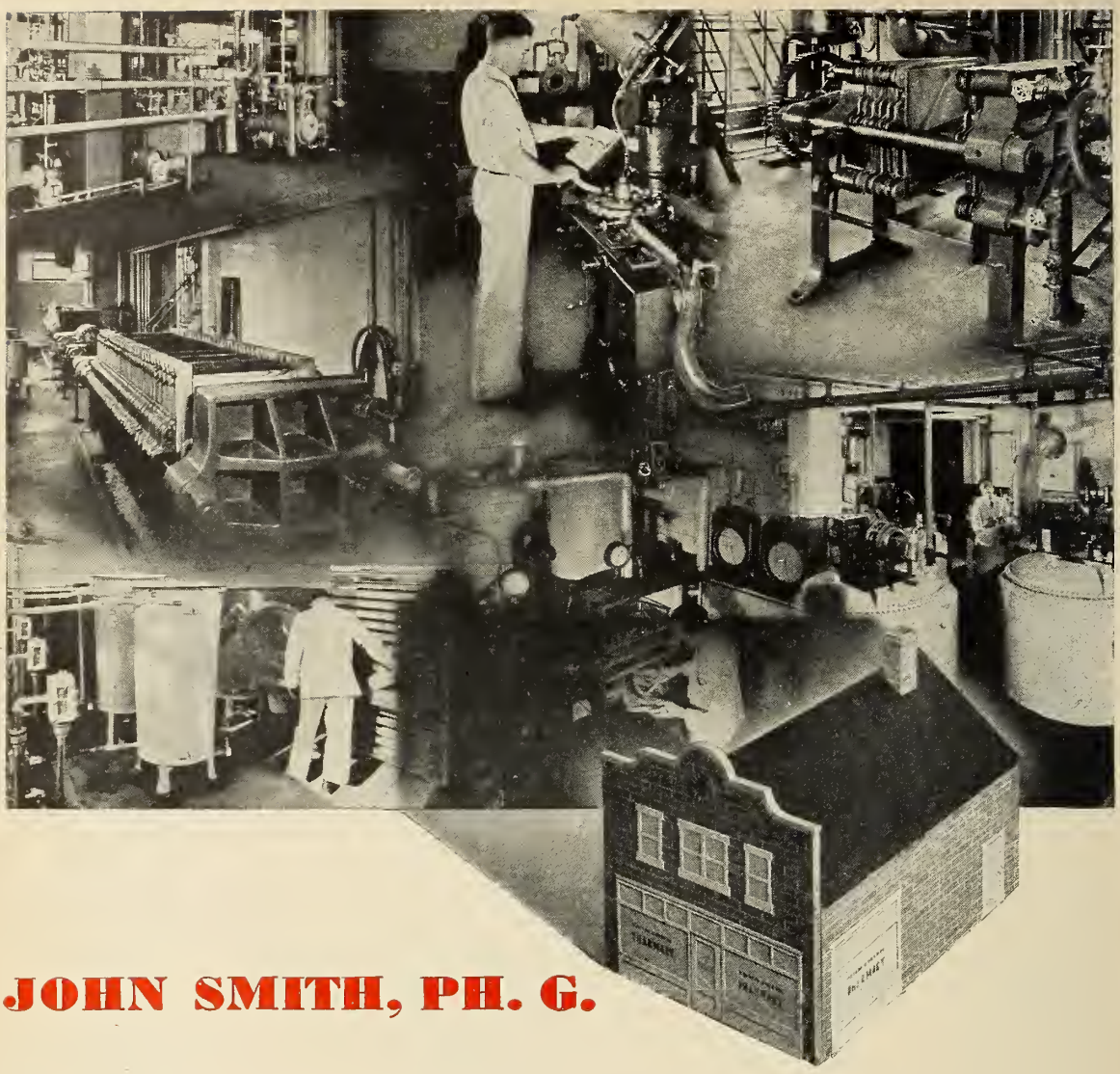
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of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

Volume 43 April, 1944 Number 4

Dermatitis of Wartime Industries in General Practice

By H. R. Foerster, M.D.
Milwaukee, Wisconsin



Assistant Professor of Dermatology, University of Wisconsin and Marquette University.

The accelerated program of industries engaged in production for war has resulted in an increase of dermatitis of various types among employes. This has created some new problems and accentuated old ones in diagnosis, treatment, and management. Some of these problems will be discussed as they concern the physician in general practice.

The necessity of keeping workers in wartime industries on the job, with a minimum loss of time from work and a minimum shifting of jobs, has increased the importance of specialized training and practical experience in industrial medicine. This applies particularly to dermatology because of the prevalence of industrial dermatitis and the multitude of minor skin injuries and inflammations that occur, especially among new employes and in new or converted industries. The step-up of industrial activities in the present emergency has increased both the incidence of cases and the difficulties of managing them. Almost all disabling industrial dermatitis has a small beginning and most of these cases can be prevented from becoming major problems by appropriate and prompt preventive and therapeutic measures. Major cases are harder to manage at present than in peacetime because of difficulties in obtaining replacements and lay-offs.

Many doctors, previously not interested or experienced in industrial medicine, have found themselves confronted with new problems created by social changes in their clientele as non-industrial communities have become centers of war industry or as established industrial areas have experienced an influx of new workers. Persons unaccustomed to factory work, women and both old and young men are more subject to injuries and dermatitis.

Because of a recent marked increase in the number of cases, especially in certain industries, occupational dermatitis has received considerable attention from the lay press. This, and the usual channels of communication among workers, has frequently resulted in an exaggeration of the prevalence and seriousness of industrial skin diseases in certain communities and plants and has caused labor personnel problems. It is often a misconception of workers that skin eruptions are transmissible, especially if they itch, that a skin disease which developed shortly after assignment to a certain job resulted from that job, and that industrial dermatitis is usually disabling and frequently incurable. If one or more workers in a group acquire occupational dermatitis, other skin eruptions occurring subsequently among fellow employes are frequently erroneously attributed to the work.

As an example of this, I will cite a recent experience. The employes in one department of a certain plant refused to work if several of their fellow workers were kept on the job. Contagion

Read at the Third Postgraduate Conference on War Medicine, the Seventy-eighth Annual Session of the Michigan State Medical Society, Detroit, September 24, 1943.

was alleged in spite of the industrial physician's statement to the contrary. My investigation supported the physician, but several days later the same agitation recurred because of a new "outbreak." I was asked to examine six patients in the presence of a union representative, the company nurse, and an official. None of the patients had a transmissible skin disease, none had an occupational dermatitis, and four different skin diseases were represented by these six cases.

The preponderance of nonindustrial dermatoses among skin diseases, even in most communities of working people, necessitates a practical knowledge of general dermatology as a basis for the practice of industrial dermatology. Likewise, the latter cannot be taught without that fundamental background for both student and teacher.

Etiology

The causes of industrial dermatitis may be discussed as they result from *the industry* itself, and as they occur because of susceptibilities of *the working personnel.*

A. The causes of dermatitis peculiar to the *industry* are of particular importance at this time and account for much of the increase in cases. They include the *chemicals* used, the *methods* employed, and the *environment factors.*

Early detection is especially important where new chemicals are introduced in war industries before their irritant properties have become generally known. This applies particularly to synthetic resins and plastics, new oils and greases, and the chemical used in the manufacture of munitions and other war materials. The problems of dermatitis in munitions and other primary military plants, though interesting are not a direct concern of the general practitioners.

1. In the concentration and form in which they are commonly used in industry, the *chemical materials* may be classified as primary irritants and as allergenic agents. Many chemicals may act either as primary irritants or as allergenic agents, depending upon the concentration in which they are used at the time dermatitis occurs. Minute physical injuries of the epidermis may result from fine metal particles in cutting oils, abrasives in soaps, or from the crystalline nature of the particles in irritating dusts. Such injuries predispose to chemical dermatitis when it might otherwise not occur.

(a) *Primary irritants* are chemicals that may cause dermatitis in any individual under certain circumstances, frequently directly after the first contact. The following is the definition accepted by the AMA Council on Industrial Health: "When a substance in a given concentration, in a given vehicle and after a given manner and length of exposure produces clinically manifested irritation on the skin of the *majority* of persons not previously sensitized to that substance, then that substance is a primary irritant under the specified conditions."[2] The recognition of any chemical as a primary irritant should result in the introduction of technical procedures to eliminate or minimize skin contacts. This is usually done but when it is not feasible, chemical substitutes should be sought or the workers may be selected for dermatologically hazardous jobs by patch testing. To be included among the primary irritants are the strong acids, alkalies, certain salts of heavy metals, solvents, essential oils, dye intermediates, and some machine oils and greases.

The manner of chemical action of primary irritants varies considerably. Alkalies exert a solvent action on the keratin of the outermost protective layers of the epidermis, thus inciting the more vulnerable tissue to inflammatory reaction. Strong alkalies and acids injure the epidermis also by direct chemical action. Solvents, such as turpentine and gasoline, remove the protective waxy secretion of the sebaceous glands and thereby expose the epidermis to chemical action.

Machine oils, mineral greases, and insoluble cutting oils act similarly. Soluble cutting oils or cutting compounds act both as keratolytics and as solvents. Cutting oils, cutting soap solutions, and lubricants are among the most troublesome and numerous causes of dermatitis in the war industries, chiefly because of the large number of workers employed at machining and the inability to protect them from such contacts. They must work with bare hands and forearms and the contacts are almost continuous through the working day. The subject of oil folliculitis and dermatitis was recently reviewed in a report of the Committee on Occupational Dermatoses of the American Medical Association.[1]

(b) *Allergenic agents* are chemicals innocuous to most skins but capable of producing dermatitis in the susceptible individual following an initial single contact and a latent period of varying length during which an allergenic response is developed. Sensitization may not occur until after many exposures occurring over periods of weeks or months and sometimes years. Among important sensitizing agents are soaps, resins, plastics, dyes, oils, accelerators, explosives, insecticides, plants, drugs, and cosmetics.

Workers with allergenic sensitivities should be placed at other work and should not be returned to the same work because of the likelihood of early recurrences of greater intensity and extent than the original dermatitis. This is difficult to do in wartime and not always possible, but it is an advisable procedure.

In the allergenic group sensitization probably results from repeated chemical action on localized areas of epidermis. This localized epidermal allergy is frequently followed by a generalized cutaneous sensitization with lesions appearing beyond the areas of contact exposure. The manner of extension of sensitization is not known but it may be centrifugal by way of the cutaneous lymphatics and also systemic by way of both blood and lymph vessel systems. It differs from atopic or somatic allergy in which the allergic shock tissue is the vascular network of the cutis and the means of dissemination is the blood stream.

2. The *methods* used in industry may be the basis for the development of dermatitis. Antiquated methods of "hand operation," such as applying chemicals with fingers or rags, dipping materials into or removing them from containers of solutions with bare hands, still persist in many industrial procedures. Contacts of this nature are more likely to result in inflammation of the skin under the pressure of increased work with less opportunity for interruptions to cleanse the skin. Much dermatitis resulting in this manner can be eliminated and has frequently been overcome by introducing the use of long handled brushes, hooked poles, mechanical appliances, protective clothing, and other measures.

Failure to anticipate the possibilities of dermatitis from newly introduced chemicals that may be spread about in the form of dust or spray, or with which the hands may repeatedly come in contact, has occasionally resulted in large numbers of cases of dermatitis appearing in epidemic-like proportions. The threatened disruption of work under such conditions has usually been effectively corrected by safety engineering procedures, such as the introduction of exhaust hoods and ventilating fans and the segregation of workers in units.

Many cases of dermatitis result from the methods and materials used in *cleaning the skin after work.* The painter commonly uses turpentine, the mechanic gasoline, others use alkaline powders and abrasive soaps and chemically contaminated cloths.

3. *Environmental factors* have much to do with the development and prevention of dermatitis. This refers to factory construction as regards ventilation, sunlight, sanitation, exhausts, and provision for adequate toilet facilities inclusive of clothes lockers, plenty of warm running water and showers. It also includes the length of consecutive working hours, recreational provisions, the living environment at home, and work done at home or elsewhere. Provisions for first aid care and instructions in factory and personal hygiene, best carried out by a well-trained industrial nurse, are of the utmost importance in the prevention and control of industrial dermatitis. A first-aid department is an indispensable factory unit.

B. The general causes of dermatitis as they apply to *the worker* are numerous.

1. The *personal habits* of the individual may predispose to dermatitis. Lack of cleanliness in person or clothing results in more prolonged contact of the skin with dermatitis-producing substances. Neglect of minor injuries that frequently occur in the day's work provide portals of entry for bacteria, fungi or chemicals. Alcoholism, fatigue, inadequate or improper diet and irregular hours probably are important factors that reduce skin tolerance to irritation and infection.

2. *Physical* and *physiological* factors predispose to dermatitis. Abnormal dryness of the skin renders it more vulnerable to the action of keratolytics and solvents, such as alkaline powders used in cleaning, turpentine in painting and mineral oils and greases in machine trades. Excessive *oiliness* favors the development of follic-

ular plugging, inflammation and subsequent infection, particularly among machinists and mechanics. *Hyperidrosis,* or excessive sweating, results in increased susceptibility to dermatitis from water soluble chemicals, especially in a dusty or fume laden environment. A *light blond skin* is more susceptible to the photosensitization dermatitis observed in industries concerned with coal tar and pitch.

3. *Preëxisting skin diseases,* especially the inflammatory dermatoses and allergic and atopic dermatitis, focal infections in teeth, tonsils or elsewhere, focal epidermal infections such as staphylococcic folliculitis and fungous infections of the feet and groins, and organic and functional disease may all predispose to dermatitis. This is a controversial field, frequently concerned with hypothetical considerations, and care should be exercised in fixing liability for dermatitis of such alleged origin. Pre-employment examinations will exclude some of these cases, but when they arise an experienced dermatologist should be consulted.

4. One of the most frequent and important causes of dermatitis as it concerns the individual worker is a *minor injury,* such as a cut or an abrasion, which opens the way for chemical irritation or sensitization. This may result in dermatitis from a substance with which the individual has been in contact for a long time.

5. An occasional but important cause of dermatitis is sensitization to the chemicals used in *first aid treatment.* Among such causes are mercurials, picric acid preparations and the sulpha drugs, to date especially sulfathiazole.

Improper or inadequate first-aid treatment, or failure to follow up first-aid measures, frequently results in dermatitis venenata or infectious eczematoid dermatitis.

Diagnosis

Diagnosis takes precedence over treatment, excepting for first-aid measures, because the employer is not obligated to accept responsibility for treatment until there is reasonable evidence of an occupational origin. Unfortunately the interest of workers frequently lags when they are confronted with personal responsibility for the care of nonoccupational disease that may impair their working efficiency. It is, however, the examining doctor's responsibility to fix the liability where it belongs and to avoid paternalism.

The Michigan compensation law states that liability exists in cases of "personal injury" occurring as a result of employment, and it provides that "the term 'personal injury' should include a disease or disability which is due to causes and conditions which are characteristic of and peculiar to the business of the employer and which arises out of and in the course of the employment."[3] This act does not apply to agricultural industry, nursery or orchard business or labor incidental to farming.

In arriving at a diagnosis both the *history* and *clinical findings* must be carefully evaluated and usually the diagnosis cannot be based on either one alone.

A. A carefully taken *history* may disclose some or all of the following observations for the basis of a diagnosis of occupational dermatitis.

1. At the time the dermatitis developed the patient may have been employed at work known to the examining physician to have caused similar dermatitis in other persons.

2. The first lesions observed by the patient may have been located at sites most intimately or most frequently in contact with an agent which may cause dermatitis. In the case of liquids or solids such sites are usually the hands and forearms, while irritants in the atmosphere in the form of vapors or dusts may first cause inflammation on the face and in the flexural areas of the neck and elbows and at sites of friction by clothing and maceration by sweat.

3. There may be a history of improvement in the inflammation on removal from the particular job suspected of having caused the dermatitis. This is of significance if the period of absence from exposure has been long enough to permit healing, and if the dermatitis has not been too severe to improve spontaneously or following a short period of treatment.

The opportunity for this observation is infrequent at present in war industries with overtime work, infrequent lay-offs, no vacations and difficulties in shifting workmen with moderate dermatitis to other jobs.

4. If the dermatitis has been severe enough

to necessitate a lay-off from work, or if the worker has been placed at another job, a recurrence of dermatitis or an aggravation of residual dermatitis, if occupational, is likely to occur when he is returned to the original job. This reactivation may not take place in the absence of contributory or predisposing factors which were concerned in the development of the original dermatitis. It also may not occur in cases of mild dermatitis in which a tolerance to the offending agent has been developed following the first exposure.

5. There may be a history of similar dermatitis in the past, following contact with similar materials. Such statements should be carefully scrutinized since the patient is usually not competent to make his own diagnosis of past dermatitis.

6. The history and examination may disclose physiological, anatomical or other predispositions to occupational dermatitis and an absence of other factors, such as allergies and previous nonoccupational dermatoses. The patient should always be questioned regarding *cleansers used* at work and at home and regarding nonoccupational activities at home and elsewhere. A negative history in this regard may be valueless and an investigation by an insurance adjuster may be indicated in occasional cases.

7. There may be a history of dermatitis first appearing at the site of an *injury* to the skin. If such incident was recognized by a responsible individual as having occurred at work, and if the dermatitis developed directly following the injury, liability exists.

8. A history may be obtained of dermatitis having developed at the approximate site of an industrial injury shortly after or within a week following *medicinal applications*. If such treatment was carried out by an employe engaged in such work or by the patient on instructions from a responsible person, liability exists even though the dermatitis is only indirectly related to the accident.

B. A careful *examination* of the patient to evaluate and differentiate the clinical evidences of dermatitis is the most important single procedure in diagnosis. Frequently inspection of the skin is all that is necessary to rule out the occupation as the cause, as in psoriasis, lichen planus and seborrheic dermatitis. These cases usually require careful investigation to determine the cause.

Serious and embarrassing mistakes in diagnosis sometimes result from incomplete examination of the skin, therefore do not examine the hands and forearms only, because the patient says that's all his trouble. Above all, routinely examine the feet and groins in patients with vesicular or scaly lesions on the hands.

There are a number of cardinal points in favor of a diagnosis of occupational dermatitis.

1. The dermatitis is usually localized to *sites of maximum* exposure or it is more severe at such sites, and this varies according to the work. An absence of lesions on unexposed sites is a helpful point though such areas may be involved secondarily or in cases of dermatitis from dusts, fumes, sweat and friction of clothing.

The distribution of individual lesions is particularly important. A diffuse involvement of the back of the hands, dorsal and lateral surfaces of the fingers and flexor surfaces of the wrists and forearms is the usual feature of dermatitis venenata acquired at work. The eruption may, however, be confined to small patches as in eczema. Grouped, deep-seated vesicles, such as are seen in epidermophytosis, may be found also in dermatitis venenata on the margins of the palms and wrists and on the sides of the fingers at the line of transition between the thick corneous layer of the flexor surfaces and the thinner more vulnerable dorsal surfaces.

2. The *type of inflammation* in dermatitis venenata varies with the intensity of the chemical reaction and the duration of the eruption. There may be only a diffuse erythematous dermatitis, or dermatitis and edema, or there may be a uniform eruption of small, superficial vesicles on an inflammatory base. The vesicles are usually thin-walled, small and closely set, and they rupture readily on rubbing or scratching, in which case there is a clear serous exudate which dries to form loose crusts. In milder cases the end-result is desquamation. Dermatitis venenata may be papular, in which case the papules are usually very small, uniform in size, numerous, and diffuse in distribution. These papules may become surmounted with tiny vesicles.

In chronic dermatitis venenata the eruption may have the features of eczematoid or eczematous dermatitis, commonly called "eczema." In these cases there is either a thickening of the skin, with exaggeration of the natural markings, a condition referred to as lichenification, or there are irregular patches which are raw or crust-covered and exude serum, and are more or less fissured. These areas of inflammation are usually diffuse but there may be small rounded plaques as in nummular eczema.

3. *Occupational injuries* preceding the development of dermatitis may result in the localization of dermatitis at the site of the injury, with latter peripheral extension and the subsequent development of scattered widespread lesions. In these cases if the eruption is of the dermatitis venenata type it may have resulted from contact of the injured tissue with chemicals used in the industry or it may have been caused by a sensitization to materials used for treatment of the injury, as previously described.

4. A common complication of occupational injury and of some cases of dermatitis venenata is *infectious eczematoid dermatitis.* This latter condition is usually characterized by an area of raw, exudative dermatitis with or without small vesicles and pustules on the periphery. There are thin, tightly adherent crusts, fissures, and undermining of the edges. Peripheral and distant lesions of similar type develop, some of which unite to form larger areas of weeping and crusted dermatitis. Simple pyogenic infections are likewise a frequent complication of occupational injures.

4. The *patch test* is a well recognized diagnostic aid but it must be emphasized that it is only an aid. Its chief value is for the recognition of allergenic sensitivity. In doubtful cases control tests should be performed. When patch tests are made with possible primary irritants the material should be diluted with an appropriate vehicle or the chemical should be applied uncovered and for a limited period, to simulate the exposure as it occurred at work.

Some of the factors that lead to skin sensitization at work, and which cannot be duplicated in patch testing, are repeated exposures over periods of weeks and months and the associated influence of sweating, occupational trauma and other environmental incidents. The epidermal hypersensitivity which has resulted in a contact dermatitis may be confined to the area of dermatitis and a patch test cannot be applied to that site until long after recovery. Under such conditions a negative test may be misinterpreted. If the material used in a test is in stronger concentration than in the occupational exposure, or if it is in contact with the skin over a more prolonged period of time, or if the patient has a polyvalent sensitivity, a false interpretation may be placed on a positive reaction.

It is sometimes advisable to make patch tests with materials with which the worker comes in contact outside of working hours or that are not related to the work. For example, I have seen dermatitis in parachute workers which resulted from fingernail lacquer and hair lacquer and that had been erroneously attributed to rayon and nylon materials.

Patients with active or quiescent eczema due to atopy or allergy may exhibit a nonspecific polyvalent sensitivity. Such individuals may show positive reactions to materials in industry with which they have not come in contact or which had nothing to do with the development of their dermatitis.

Differential Diagnosis

Ever since industry has been on a war program, along with a marked increase in industrial dermatitis I have also observed a larger percentage of nonoccupational skin diseases among industry referred cases than in previous years. Many of these simulated occupational dermatitis and required careful investigation before the causes were determined. Other cases were obvious examples of nonoccupational dermatoses. There will always be some cases in which a decision as to occupational liability cannot be made, especially if the clinical picture has been confused by chronicity and treatment measures before dermatologic consultation is sought. Malingering is uncommon and usually consists of interference with healing by rubbing, scratching or picking of pre-existent lesions, or of wilful neglect of treatment. The fictitious production of skin lesions to obtain compensation or release from a job is rare in my experience.

(a) The majority of cases of occupational dermatitis are instances of dermatitis venenata and of eczematoid dermatitis. They usually re-

quire careful investigation. However, when occupational dermatitis has distinctive features of localization or type of eruption it may be possible to make a diagnosis without resort to the history. Likewise, an eruption of plant or weed dermatitis may be sufficiently distinctive to rule out the occupation as the cause. Vesicles of variable size in linear grouping, especially along scratch marks, and with clusters of lesions, suggest a plant or weed dermatitis. In ivy dermatitis there are frequently large or confluent blisters, severe dermatitis and much edema. An oil folliculitis and furunculosis may be so distinctive in its localization and in the association of oil comedones that only a cursory history taking is necessary to establish liability.

(b) The vesicles of *epidermophytosis* are usually grouped in clusters and are more deeply seated and not so easily broken as those of dermatitis venenata, though they may also be superficial and thin walled. Epidermophytosis is not common on the hands. A more frequent cause of confusion is the *epidermophytid* eruption of the hands secondary to epidermophytosis elsewhere. This is usually a symmetrically distributed eruption involving the palms and all surfaces of the fingers, but more commonly the sides. It is usually a vesicular eruption and the vesicles are thin walled, superficial and grouped in clusters. There is always an associated focus of epidermophytosis elsewhere, most commonly between the toes or on the soles.

Epidermophytids may also be symmetrically distributed, scaly, mildly inflammatory macules with a distribution similar to that of the vesicular type. In such cases the trichophyton test is positive but this is not always a dependable diagnostic aid.

(c) *Dysidrosis* is a neurogenic type of vesicular eruption, usually confined to the sides of the fingers and more readily confused with epidermophytid than with contact dermatitis.

(d) *In toxic dermatitis* of internal origin, due to autotoxic factors, drug sensitivity and occasionally focal infection, the eruption is usually macular or papular and the papules are larger and fewer than in contact dermatitis and likely to be grouped and distributed predominantly over extensor surfaces. The lesions are symmetrically distributed because of their hematogenous source and they frequently appear also on the face and trunk. I have seen many cases of this type which have been erroneously considered instances of occupational contact dermatitis or that have caused confusion in diagnosis.

2. *Nummular or idiopathic eczema, disseminated neurodermatitis* which is an expression of allergy, and *infectious eczematoid dermatitis* that is not the direct consequence of an industrial dermatitis or injury, are three important dermatoses of frequent occurrence which usually require dermatologic consultation for their differentiation from occupational dermatitis and for their management. They may be closely simulated by long-standing cases of eczematoid contact dermatitis and their clinical features cannot be discussed at this time. Occasionally cases of diagnosable dermatitis become controversial medicolegal cases in which the question of liability cannot be determined with reasonable certainty because of the time interval and the clinical changes that have occurred since the inception of the dermatitis. These are valid arguments for early dermatologic care.

The services of a dermatologist should always be obtained promptly in cases of doubtful etiology and in those in which satisfactory response to treatment does not occur within a few days or weeks. If the medical setup permits, it may be expedient to refer dermatologic cases directly to a dermatologist on their inception.

Prevention

The first step in the control of industrial dermatitis is prophylaxis or *prevention.* This is a concern chiefly of the medical department of large industries, and of a full-time or part-time industrial physician or the auxiliary nursing and first-aid personnel in smaller organizations. The dermatologist can be of much help in defining possible causes of dermatitis and outlining protective measures, and in prescribing appropriate "dermatologic-first-aid" treatments and procedures.

The essentials of the prevention and control of industrial dermatitis include (a) *elimination of unnecessary hazards,* (b) *selection* of a suitable working personnel in work where the incidence of dermatitis is high, (c) *instruction* of employes in skin hazards and preventive measures, (d) *training* of foremen and forewomen in su-

pervising preventive measures, inclusive of the personal hygiene of the workers, (e) *routine inspection* by first-aid assistants or an industrial nurse of all workers with skin injuries and inflammations for the early recognition of dermatitis, and (f) prompt *removal from irritant contacts* at the inception of dermatitis. For details on preventive measures and protective creams the reader is again referred to the recent report of the Committe on Occupational Dermatoses.[1]

Treatment

1. The treatment of *acute dermatitis* varies somewhat with the severity and type of dermatitis. In all cases it includes the removal of aggravating factors, such as the continued use of soaps and other irritating cleansers, continuing at work with the causative agent if the inflammation is pronounced, and self-medication or improperly directed treatment by a nurse or physician.

Antiseptics should not be used in cases of dermatitis unless there is also infection, or threatened infection, because of injury associated with dermatitis. To combat infection in cases of dermatitis use warm boric acid solution compresses, weak potassium permanganate compresses (1 to 10,000 to 1 to 5,000) and U.S.P. Boric Acid ointment in full strength or reduced one-half with vaseline. Compresses should be thoroughly wet and abundantly thick and covered to stay warm, but they should not be as hot as they are customarily used in injuries and primary infections. Compresses should be renewed frequently for the desired effect but they should not be so continuous as to result in maceration of the skin. Most nurses need special instruction in dermatologic compressing.

An aluminum acetate lotion, frequently sponged on the affected parts, or applied as a wet dressing, is useful in acute dermatitis, whether it is dry, vesicular or exudative, and also if infection is present. The following prescription is useful and may be varied in strength: ℞ 4 per cent aluminum acetate (Burow's solution) oz. 1, 3 per cent sol., boric acid q.s. ad oz. 8. In acute vesicular dermatitis the following lotion is likewise useful but should not be applied as a wet dressing: ℞ So. plumbi subacetatis dilut. oz. 1, Glycerin dr. 2, 3 per cent Sol. acid boric q.s. ad oz. 8. Either of these lotions may be used repeatedly during the day but are drying and should be supplemented by application at night of a plain zinc oxide ointment or a zinc oxide starch paste, such as ℞ zinc oxide dr. 1½, amyli pulv. dr. 1½ petr. alba q.s. ad oz. 2.

In a dry acute dermatitis a calamine lotion may be prescribed but in exudative cases a calamine lotion should not be used for it will "cake" with the serum and result in aggravation of dermatitis because of interference with drainage: ℞ Calaminæ preparat. oz. ½, zinci oxidi oz. ½, glycerin dr. 3, aqua calcis oz. ½, aqua destillata q.s. ad oz. 8.

Zinc oil or an emulsion may be used in erythematous dermatitis instead of a lotion, or in preference to a lotion in vesicular or exudative cases. ℞ Zinci oxidi oz. 2, oleum olivarum q.s. ad oz. 6, ℞ Zinci oxidi dr. 1, calaminæ preparat. dr. 1, oleum olivarum et aqua calcis aa q.s. ad oz. 6.

From ¼ per cent to 1 per cent phenol may be added for anti-pruritic effect, keeping in mind that phenol may occasionally irritate and that phenol preparations must not be covered by a bandage or dressing.

2. *Subacute dermatitis* may be treated similarly to acute dermatitis. In addition slightly stimulating ingredients may be added. One per cent resorcin may be added to a boric or aluminum acetate lotion, and 1 per cent to 2 per cent salicylic acid to a zinc paste or ointment. Ichthammol and naftalan may be used in 2 to 5 per cent strength in an ointment or paste base. In subacute dermatitis with infection 2 per cent ammoniated mercury may be used or individual pustules may be painted with a 2 per cent aqueous solution of gentian violet. Ammoniated mercury may occasionally cause dermatitis and frequently aggravates an existing dermatitis. Three per cent tincture of iodine may be best for cuts and bruises because of the possible occurrence of mercurial sensitization following the use of mercurial tinctures. Two per cent to 5 per cent ammoniated mercury ointment is best for skin infections in the absence of dermatitis. The sulfa drugs, particularly sulfathiazole, should not be used routinely for skin infections because of the frequency with which these drugs cause sensitization either when used locally in the presence of dermatitis or when given orally. Either mode of administration may sensitize the patient to subsequent use of the drug locally or by mouth and severe generalized dermatitis may result. There are of course definite indications for the sulfa

drugs in severe pyogenic infections, particularly in furunculosis and erysipelas.

3. In chronic industrial dermatitis some of the measures used in acute and subacute dermatitis are frequently indicated. Ichthammol or naftalan are used 5 to 10 per cent strength, and crude coal tar, oil of cade, and liquor carbonis detergens, sulphur and salicylic acid in 2 to 5 per cent strength, in pastes, creams or ointments. 2 to 10 per cent silver nitrate solution may be used for fissures and 2 to 5 per cent ammoniated mercury ointment for infections. X-ray treatment is very useful in certain cases of chronic dermatitis but its use should preferably be restricted to the dermatologist because of the potentialities for permanent damage of the skin.

4. *Internal treatment* in industrial dermatitis varies with the individual case and is usually necessary only when the dermatitis is extensive or chronic. The most frequently useful for direct effect on the dermatitis are calcium preparations which may be given orally or by injection. Barbiturates and bromides may be used conservatively, chiefly in the acute cases with severe pruritus and insomnia. Alkaline and laxative mixtures, tonics and hematinics should be prescribed when indications for them exist. Endocrine and vitamin therapy, the sulpha drugs, arsenicals, vaccines and foreign protein injections are useful in occasional properly selected cases. All of these should be used conservatively when indicated. The simplest treatment measures are usually the best and if they fail a dermatologic consultation and survey is properly more advisable than reference to detailed articles on dermatologic treatment.

Much that is of importance in industrial dermatitis has been omitted from this discussion but it is hoped that the general outline presented will help to clarify the management of industrial skin cases for the general practitioner.

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MSMS

Avitaminosis in Dermatology and the Value and Limitations of the Sulfa Group in Skin Diseases

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Avitaminosis is due to inadequate utilization of vital substances contained in food. It is usually due to an unbalanced diet in which food containing the necessary vitamins is not consumed. Avitaminosis may occur, however, when the food supply is adequate due to several factors described in the paper. The chief vitamin deficiency diseases include pellagra, beriberi, scurvy (scorbutus) and rickets. The cutaneous avitaminoses characterized by follicular hyperkeratosis include Darier's disease (keratosis follicularis), pityriasis rubra pilaris and possibly keratosis pilaris, lichen pilaris seu spinulosis (Crocker) and xerosis. A new syndrome due to vitamin A deficiency is characterized by follicular hyperkeratosis, keratomalacia and nyctalopia (night blindness). Vitamin G (B_2) riboflavin deficiency is represented by a syndrome characterized by perleche and dermatitis seborrheic-like lesions together with ocular and oral mucous membrane involvement. The iritis of rosacea is now considered a riboflavin deficiency. Vitamin C (ascorbic acid) deficiency is represented by scurvy.

Pellagra is now considered to be an example of multiple avitaminosis, the chief deficiencies being nicotinic acid, thiamin chloride, riboflavin and vitamin B_6.

The sulfa group of compounds have been used in a large number of dermatoses, both internally and locally. They are of distinct value in erysipelas, erysipeloid, chancroid, lymphogranuloma venereum, hydradenitis suppurativa, lymphangitis pyoderma, gangrenosum and chronic streptococcus ulcers. Dermatitis herpetiformis is well controlled with sulfapyradine. Impetigo and other pyodermic infections respond well to sulfathiazole incorporated in an ointment base. This is also very valuable used in solution or ointment base in the treatment of burns.

■ Avitaminosis is due to inadequate utilization of vital substances contained in food. It usually occurs with an unbalanced diet in which food containing the necessary vitamins is not consumed. Avitaminosis may occur, however, when the food supply is adequate. A vitamin deficiency in the presence of adequate food supply may be induced in several ways: first, through loss of vitamins in the intestinal canal from intractable diarrhea; second, through inability of the intestinal canal to absorb normally the essential dietary constituents; third, through lack of a bodily factor required to convert vitamins into a usable

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form; fourth, to a high individual vitamin requirement; and, fifth, to the inhibition, by infection, of the functions of vitamins (Rhoads).[14]

The chief vitamin deficiency diseases are pellagra, beriberi, scurvy (scorbutus) and rickets. The cutaneous avitaminoses characterized by follicular hyperkeratosis include Darier's disease (keratosis follicularis), pityriasis rubra pilaris and possibly keratosis pilaris, lichen pilaris seu spinulosis (Crocker) and xerosis.

Vitamin A.—This vitamin plays an important part in the metabolism of the epithelium of the skin and mucous membranes. The association of nyctalopia (night blindness), keratomalacia and follicular hyperkeratosis is a well recognized syndrome due to vitamin A deficiency. An excellent description of this syndrome was given by Frazier and Hu[2] in a group of patients observed in clinics in China. The age of the patients in this group ranged from four to thirty-one years. The diet previous to development of symptoms consisted largely of cereals with some white cabbage and salted vegetables. In infants and young children the cutaneous changes were xerotic while in older children and adults follicular hyperkeratosis was present. The papules were described as being firm, conical or hemispherical and pigmented. In addition horny plugs or spines protruded from the hair follicles. Lowenthal[9] observed the association of night blindness, xerophthalmia and follicular hyperkeratosis in soldiers in East Africa. In all of these cases the condition cleared up with the use of cod liver oil. Lehman and Rapaport,[6] in this country, reported upon a vitamin A deficiency affection occurring in children characterized by horny papules often having broken stumps of hair at the summit projecting from hair follicles. There was diminished perspiration and the clinical picture was that of xeroderma. Photometric studies confirmed the diagnosis. Vitamin A in the dosage of 100 to 300,000 international units was specific.

The best sources of vitamin A are butter, cream, egg yolk, fish liver oils and green leafy vegetables.

Keratosis Pilaris

This disease occurs at any age but is more common at the developmental period. It is characterized by the presence of minute horny plugs or papule-like lesions occupying the pilosebaceous follicles and situated chiefly on the arms and thighs though they may occur on any portion of the cutaneous surface. The papules are pinhead-sized, or slightly larger, grayish, acuminate or convex, sometimes capped by a scale or pierced by a hair. The skin presents a rough nutmeg graterlike surface.

Etiology.—The affection often occurs with ichthyosis and is more active in cold weather. Vitamin A deficiency is now considered of etiological importance. Treatment with foods rich in vitamin A together with 25,000 units of the vitamin three times daily give good clinical results.

Lichen Pilaris Seu Spinulosus (Crocker)

This affection occurs almost exclusively in childhood and is characterized by minute papules situated in the pilosebaceous follicles each having a projecting horny spine. The lesions are usually grouped into patches and occur chiefly on the neck, the buttocks, trochanteric regions, the abdomen, thighs, popliteal spaces and the extensor aspects of the arms. The face, hands and feet are commonly spared. The eruption appears in crops and is usually symmetrically disposed. Early the papules are red, but they soon assume the normal hue of the skin. It is interesting to note that this condition occasionally occurs in patients having folliculitis decalvans of the scalp.

Etiology.—This has only been conjectured until recently when it was found to probably belong to the vitamin A deficiencies.

Pityriasis Rubra Pilaris (Devergie)
Lichen Ruber Acuminatus (Kaposi)

This is a keratotic papular disease commonly beginning in the second decade of life but may begin as early as the first year. The characteristic lesion is a keratotic or horny papule situated in a hair follicle. The usual picture consists of a palmar and plantar keratoderma with patches of keratotic papules around the knees, on the back and extremities. These patches resemble psoriasis. In addition there is usually a seborrheic dermatitis like eruption on the face and in the scalp. Keratotic papules occur on dorsum of the fingers which are characteristic and are of diagnostic importance. The disease runs an intractable course and its etiology was entirely unknown until recently when it was demonstrated that a vitamin A deficiency was concerned in its production. In three cases Brunsting and Sheard[1] investigated the degree of night blindness by

measuring the threshold of dark adaptation. Peck and Chargin[11] in their investigations found a low vitamin A content in the blood. Treatment in these cases with vitamin A produced improvement but rather slow. We have had similar experiences.

Keratosis Follicularis, Darier's Disease

This disease begins as a rule in childhood and many cases are on record where it began in infancy. It is characterized by hyperkeratotic lesions involving the pilosebaceous follicles. The early lesions are papules which soon become crust covered and coalesce producing papillomatous, vegetating and tumorlike new growths. The eruption often begins about the head and face and spreads to the extremities, the front of the chest and the inguinal and genital regions. The crusted lesions are brownish and greasy to the touch and eventually become deep brown or darker in color. On the face, temples, the inside of the concha of the ears and about the angles of the nose and lips dark, even blackish, greasy crusts form. The scalp is the seat of an oily seborrhea and the vegetating and papillomatous lesions are found in the axillary and genital region. There is also some palmar and plantar keratoderma. The disease occurs often in several generations of a single family. Darier thought the disease was produced by a psorosperm. Bowen proved these bodies to be cell transformations and not living organisms. Peck[12] and others consider the disease a vitamin A deficiency affection. They suggest an hereditary weakness in vitamin A absorption or in conversion of provitamin A to vitamin A. These authors cured three cases using 200,000 U.S.P. units per mouth daily.

Vitamin G. (B_2) Riboflavin.—Sebrell and Butler[15] described a symptom complex due to riboflavin deficiency which included lesions at the angles of the mouth resembling perleche. Macerated linear fissures occurred at the angles of the mouth together with a red scaly inflammation of the vermilion border of the lips which at times presented a red, shiny, denuded appearance. There was an associated mild greasy seborrheic dermatitis in the nasolabial folds and inner and outer canthi of the eyes. Occasionally the seborrheic dermatitis involved the ears and other portions of the face. At times a crusted and superficially eroded lesion was present inside the nares with a fissure at the mucocutaneous junction. The tongue presented a magenta color which contrasted with the bright red tongue of pellagra. Sometimes these lesions had an associated vascularizing keratitis. This produced photophobia, dimness of vision, circumcorneal injection and burning sensations of the eyeball. Conjunctivitis is simulated and corneal opacities, mydriasis and iritis occur. Riboflavin in the dosage of 15 to 50 mg. daily is specific for this condition.

Rosacea Keratitis.—This condition was early described by Kissmeyer and others.[4,5,8] He stated that both the bulbar and palpebral conjunctivae may be the seat of dilation of vessels and diffuse inflammation often accompanied by a marginal blepharitis. Pinhead-sized grayish-red nodosities, prone to ulceration, occur chiefly at the bulbar angles. The corneal changes consist of a well defined pannus composed of fine vessels extending from the margin toward the center of the cornea. A deep subepithelial grayish infiltration may occur on any portion of the cornea. Ulcers preceded by abrasions, accompanied by infiltration, and vascularization which may end in scar formation and impairment of vision occur in the epithelium. This condition is now recognized as a riboflavin deficiency and is successfully treated with this vitamin.

The best natural sources of riboflavin are milk, eggs, liver, muscle and yeast. The dosage ranges from 2½ mg. to 50 mg. daily.

Vitamin C (ascorbic acid) deficiency is represented by scurvy. This condition is readily cleared up and prevented through the free use of juices of citrus fruits and tomatoes which contain much ascorbic acid. Other sources of ascorbic acid are green leafy vegetables and berries.

The general symptoms need not be described here other than to say that the disease is not uncommon in this country and that the lesions in the mouth and the petechial hemorrhages in the skin are characteristic.

Pellagra

Pellagra[10] became endemic in the Southern States in 1907. Cases multiplied rapidly so by 1910 it was estimated that there were 1,000 cases. This had increased to 250,000 in 1930. Since then a decline has occurred so that in 1938 there were about 100,000. In Illinois we had a

large number of the endemic type which were studied by us between the years 1909 and 1912. At present only sporadic cases exist in Illinois. This is true of all of the states except those in the cotton belt.

The major portion of endemic cases occur from March until June, inclusive. From September until March only a few cases remain active.

Whether of the endemic or sporadic type symptoms occur in three systems of the body—the skin, gastro-intestinal and the nervous system.

The lesions on the skin closely resemble sunburn and occur chiefly on exposed parts, such as the hands, neck and face. The forearms, genital areas and others are also often attacked. A striking feature is the exact symmetry in the placement of the lesions. A diagnostic picture is presented on the hands and wrists. Here the eruption reaches only about three-fourths of the circumference of the wrist.

In the gastro-intestinal tract diarrhea is a common symptom. Hydrochloric acid is usually absent from the stomach and a stomatitis and glossitis is usually present. Paresthesia of the buccal mucosa is an early symptom and this may also involve the pharynx and esophagus. Nausea and vomiting may occur and indigestion indicated by eructation of gas and abdominal pain after taking food is common. The tongue is practically always involved and presents characteristic changes. It becomes swollen and denuded presenting a dry appearance, and in severe cases superficial ulceration along its edges and on the under surface with yellowish sloughings which bleed easily. The ulcers are superficial and heal without scar formation. In mild cases the tongue may be reddened and present smooth areas, the so-called bald tongue of Sandwith. At times the redness extends over the vermilion portion of the lips. At times the oral commissures become fissured and erosions occur in the immediate vicinity on the skin.

The nervous system presents symptoms induced by acute intoxication. In the subclinical group the nervous symptoms correspond to those found in neurasthenia. They include fatigue, insomnia, anorexia, vertigo, burning sensations and numbness in various parts of the body, palpitations, nervousness, a feeling of unrest and anxiety, headache, forgetfulness, apprehension and distractability. In well developed cases various types of psychoses are exhibited. These include loss of memory, disorientation, confusion and confabulation. At times excitement prevails and at others there are signs of mania, depressions and delusions. Paralysis occasionally follows numbness of the extremities. In advanced cases a spastic and ataxic gait is often associated with peripheral neuritis which is very painful and occurs in the feet and legs. Spies states that two-thirds of the patients with severe pellagra manifest central nervous system involvement or peripheral neuritis or both. Goldberger found that about 2 per cent of mental cases required institutional care.

Etiology.—It now is generally accepted that the disease is largely an avitaminosis. Factors predisposing to improper utilization of the food include alcoholism and certain diseases that interfere with the ingestion, assimilation or proper utilization of food. These include tuberculosis, gastro-intestinal disease, hepatic cirrhosis, cardiac and renal disease, diabetes, dysentery, hookworm and others. Photosensitization of the skin by hematoporphyrin has been suggested as a cause of the dermatitis. That the sun's rays are effective in producing lesions in exposed areas has been demonstrated by ourselves and many others.

Goldberger and associates were able to produce pellagra in human beings by using a diet consisting of wheat flour, corn meal, grits, starch, rice, Irish and sweet potatoes, some green vegetables, fats, sugar and syrup. They were able to prevent and clear up the disease with food rich in pellagra-preventive vitamins. This includes milk, lean meat, turnip greens, tomatoes, green peas, spinach and cow peas.

Nicotinic acid is specific for the disease. Thiamin chloride is recommended for the neuritis, riboflavin for the cheilitis and vitamin B_6 is an aid. Liver and yeast are also valuable aids.

While a dietary deficiency is all important in producing the disease, it cannot be said that other factors not yet demonstrated may not enter into the picture. The demonstration by Goldberger and his associates of the part played by diet was an achievement seldom achieved in medicine.

Sulfa Compounds

This group of drugs has been used extensively in a large number of dermatoses both internally and locally.

They have been found to be of distinct value in chancroid, lymphogranuloma venereum, erysipelas and cellulitis, erysipeloid, hydradenitis suppurativa, lymphangitis, pyoderma gangrenosum, dermatitis herpetiformis, and chronic staphylococcic ulcers. Locally impetigo and other pyogenic infections respond well as do also burns of varying degree.

The untoward reactions[7] to the various members are characteristic and are of fairly frequent occurrence but are not of sufficient importance to limit the use of the drugs except in fairly severe cases. It has been our experience that if no untoward reactions occur within the first three days the drugs may be used indefinitely.

These reactions occur in from 2 to 5 per cent of patients treated. They may be morbilliform, scarlatiniform, purpuric, varioliform, urticarial, papular, vesicular, bullous or nodular in character. In addition, fixed eruptions, stomatitis and exfoliative dermatitis are occasionally seen. Photosensitization is a factor in some instances. These eruptions may occur from the first to thirtieth day but are most common between the fifth and ninth day. Some general toxic symptoms include elevation of temperature, acute hemolytic anemia, hepatitis, leukopenia with granulocytopenia, acute agranulocytosis (rare), hematuria, anuria and some ocular and auditory disturbances and, rarely, psychoses.

Chancroid.—Sulfathiazole internally with injections into the bubo of a 5 per cent solution of sodium sulfathiazole after aspiration is very efficient.

Erysipelas.—Sulfanilamide given in adequate dosage shortens the course of the disease and greatly reduces the mortality rate. The reports of several hundred cases bear out this statement.

Erysipeloid.—Several reports confirm the value of sulfathiazole in the treatment of this affection.

Lymphogranulomatosis inguinales (lymphopathia venereum).—This is a venereal disease resembling both syphilis and granuloma inguinale. The Frei intradermal test is a valuable diagnostic and therapeutic procedure. Sulfanilamide internally has been of much therapeutic value.

Pyoderma (ecthyma gangrenosum).—This is a serious deepseated gangrenous affection which presents a difficult therapeutic problem. Very extensive deeply destructive ulcerations occur. We have seen a large portion of the abdominal wall destroyed in the process. There is usually an associated ulcerative colitis in these patients. In a very extensive ulcerative case we employed sulfathiazole internally and locally together with liver and iron with complete success. Others have had similar experiences.

Dermatitis herpetiformis.—In this very resistant disease sulfapyridine has been of great value. The treatment has to be continued over a period of several months to prevent exacerbations or recurrences. Our method is to use saturation dosage until the symptoms subside, then give .5 gm. t.i.d. over an indefinite period. Always have the patient drink plenty of water during the treatment. It is interesting to note that other members of the sulfa group have not been of service in this disease.

Dermatitis Calorica.[3]—Much work has been done during the present war on the treatment of burns, owing to the large number of casualties in this particular department. It is only the part of the sulfa group that can be discussed here. Pickrell[13] suggested the use of a 3 per cent solution of sulfadiazine in 8 per cent triethanolamine sprayed hourly the first day, every two hours the second day, every three hours the third day and every four hours the fourth day. This produces a collodion-like impervious covering over the burn which exfoliates in ten or twelve days at which time sulfadiazine or saline compresses are applied. For mild burns Pickrell advised a two-hour spray followed by 5 per cent sulfadiazine and 8 per cent triethanolamine in a stearic base. Solutions and ointments of sulfathiazole are less likely to be irritating than those containing sulfadiazine. Sulfanilamide may be used as a dusting powder but care should be taken that overabsorption of the drug does not occur.

Impetigo and Ecthyma.—A 5 per cent sulfathiazole ointment is a clean and efficient method of treating these pyodermas. The formula used by the author since the beginning consists of sulfathiazole 5 per cent, ol. morrhuate of mineral oil 10 per cent, lanolin qs. 100 per cent. This is nonirritating and may be used in young children and usually clears up impetigo in five to seven days.

Hydradenitis Suppurativa.—This is a deep-seated pustular condition usually situated in the axillary spaces, but may occur also in anal region, about the nipples, scrotum and labia majora. The affection is supposed to be an infection of the apocrine sweat glands. It is very resistent to treat-

ment. Sulfanilamide and sulfathiazole administered internally have been useful. Other treatment such as roentgen rays and surgical excision is often necessary.

Résumé

Notwithstanding the enormous quantity of vitamins being indiscriminately used by the laity they are valuable and play an important role in therapy in several diseases. In 1939 Sebrell discussing nutritional diseases stated that in the preceding year 100 million dollars had been spent for vitamins independent of those sold on prescription. Early in 1943 a survey showed that from 25 to 33 per cent of the drug business consisted in the sale of vitamins. The isolation and elaboration of the various vitamins has contributed much to the therapeutic armamentarium of the medical profession.

In regard to the sulfa drugs it may be stated that their profound effect on several serious diseases is of utmost importance. Their extraordinary effect on some of the initial affections in which they were used led to a very extensive therapeutic trial. In general medicine they are practically specific in several important diseases and in dermatological affections previously discussed they produced results not previously attained. Their development is one of the striking therapeutic advancements in modern medicine.

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Establishment of the First Public Health Laboratory in the United States

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The Michigan State Board of Health is not an executive body; its powers are wholly advisory, and it has accomplished the great work, for which it is universally given credit, by educational means; these it hopes to strengthen and widen by the laboratory of practical hygiene which you have been asked to establish.

—Dr. Victor C. Vaughan, 1886

■ That Professor Robert C. Kedzie of the Agricultural College at Lansing was the first laboratorian to give extensive attention to hygienic problems in Michigan is almost self-evident from a study of the literature, despite the absence of any such statement to that effect. His numerous researches on illuminating oils, poisonous wallpaper and adulterated foods won for him a wide reputation over the entire country. With his resignation from the State Board of Health in 1881, interest in the investigative aspects of public health work in the state was given a temporary setback. Prof. Kedzie did, however, continue to perform special analyses for the Board on request. To his boundless zeal and ingenuity may be credited many of the events which were to follow.

In 1882, at a meeting of the State Board of Health, the following resolution was introduced by Dr. Henry F. Lyster:

Whereas, it is essential to the health and well-being of the people that all articles of food offered for sale shall be free from adulteration;

Resolved, That the sum of one hundred and fifty dollars is hereby appropriated for the purpose of analysis and reports by experienced chemists on such articles of food as may be submitted by the officers of this Board. This appropriation being for the year 1882.[1]

In the minutes of the meeting it is recorded that "The Secretary was authorized to have made analyses of tissues, excretions, and secretions of the human body, in aid of the determination of the cause of disease, the expense not to exceed

one hundred dollars."[2] A committee was subsequently appointed to investigate the subject of metallic poisoning by materials used for cooking and storing food. Dr. Kedzie's investigation of various fruit containers revealed that the fruit invariably contained large amounts of lead and tin.[3]

At a meeting of the Board in 1884, Dr. J. H. Kellogg of Battle Creek recommended that a part of the appropriation of the Board be used for making special investigations.[4]

Cheese Poisoning and Tyrotoxicon

Events occurring in 1885 served to intensify interest in still another laboratory problem. From various parts of the state—at Middleville, Jerome, Jonesville, and Big Rapids—came news that persons eating cheese had become suddenly and violently ill.[5] In all, some three hundred such cases of apparent poisoning were reported to the State Board of Health.[6] In one city alone, over one hundred persons were thus affected.[7] These outbreaks were called to the attention of Dr. Victor C. Vaughan of the Medical School at the University of Michigan by Dr. H. B. Baker, since at that time Dr. Vaughan was chairman of the standing committee on Foods, Drinks, and Water Supply.[8] He and his associates tried various experiments on themselves to ascertain the cause of the sickness, finally isolating a poisonous principle. "For this substance," he said, "I have proposed the name of tryotoxicon—cheese-poison."[9] Because of his discovery, Dr. Vaughan was referred to by Dr. Conrad George of Ann Arbor and others of his associates as "the man who had demonstrated the first toxic ptomaine."[10]

It was Dr. Vaughan's opinion that tyrotoxicon had formed in the various samples of cheese sent him, as the result of bacterial action in a closed milk container.[11] Considerable numbers of B. Subtilis were also found in several specimens. In a paper read before the State Board of Health in 1887, Dr. Vaughan called attention to the great similarity between symptoms of poisoning by tyrotoxicon and those of cholera infantum—"If all these facts be taken into consideration, . . . it will certainly seem at least probable to anyone that tyrotoxicon may be the cause of cholera infantum," he said.[12]

Dr. George Sternberg, then of Johns Hopkins University, was also sent samples of the cheese responsible for illness, with the request that he ascertain the cause of the poisoning.[13] It was his opinion likewise that the poisoning was "probably a ptomaine which had developed in the cheese as a result of the vital activity of a micrococcus which had been killed by its own poisonous products."[14]

With Dr. Vaughan's announcement that the poisoning was due to tyrotoxicon, the State Board of Health authorized him to prepare a circular for distribution throughout the state on the subject of tyrotoxicon and its relation to cholera infantum.[15] He was also asked for frequent reports on the subject at meetings of the Board, and by leading scientific journals.[16] An abstract of one paper he prepared on the subject was sent to all newspaper sanitary and medical journals, physicians, dairymen, cheese factories, and manufacturers and dealers in dairy supplies of the state.[17]

In 1887, another similar outbreak occurred in Milan. This one caused considerable gossip in the state because of the fatal termination of three cases. Deliberate poisoning was openly suggested by village wiseacres. In consequence of Dr. Vaughan's investigations, many of these unjust accusations, made at the time by inquisitive neighbors, were stopped.[18]

As the result of his experiences in these outbreaks of sickness about the state, Dr. Vaughan was led to believe that a full-time laboratory was essential to carry on the work. At a meeting of the State Board of Health on January 8, 1884, he voiced the need for a fully-equipped sanitary laboratory at the University in which to carry on these investigations.[19] Apparently nothing was done about his request at the time for no mention is made in the literature which followed until October, 1886. At a regular meeting of the Board on that date, a resolution was adopted requesting

[2]Ibid., X, xxxv.
[3]Ibid., XI, xxxii.
[4]Ibid., XII, xxxvii.
[5]Ibid., XII, xl; ibid., XII, 122.
[6]Ibid., XIV, 154.
[7]Ibid., XII, 122.
[8]Ibid., p. 128.
[9]Ibid., XIII, 225.
[10]Trans. MSMS, V (1887), 68.
[11]An. Rep. S.B.H., XIII, 225.
[12]Ibid., XIV, 160.
[13]Ibid., XII, xxix.
[14]Ibid., XIII, 219.
[15]Ibid., XV, xlvi.
[16]Ibid., p. 177; ibid., XIV, 154; ibid., XIII, xxxii; ibid., XVI, xxxviii.
[17]Ibid., XVI, xlviii; an outbreak of poisoning caused by eating ice cream by eighteen residents of Lawton, Michigan, was found to be due to tyrotoxicon by Dr. Vaughan. An. Rep. S.B.H., XIV, 155.
[18]An. Rep. S.B.H., XV, i; ibid., p. 12.
[19]Ibid., XII, xxxvii; according to Dr. H. B. Baker, Prof. Vaughan's researches were widely known and acknowledged throughout the world before the establishment of the hygienic laboratory. (An. Rep.) S.B.H., XV, xliv.

the Regents of the University of Michigan to establish a hygienic laboratory at Ann Arbor:

> Resolved, That the regents of the University be respectfully requested to consider the advisability of establishing a laboratory of hygiene, in which original investigations, chemical, microscopical, and biological,—shall be carried on, and attention shall be given to the subjects of analysis of water, the adulteration of food, and the practical investigation of other questions in sanitary science; regular reports of important results of laboratory work to be made to the State Board of Health.[20]

In December of the same year a committee from the State Board of Health consisting of Drs. Henry F. Lyster, Victor C. Vaughan, and Henry B. Baker appeared before the Regents of the University of Michigan to request the establishment of a hygienic laboratory. Individual presentations were made by each of the members of the Board.[21] On this occasion Dr. Lyster said, "We ask as representatives of the State Board of Health, after thirteen years' study of the public health interest, that you ask from the State Legislature such an appropriation as may be necessary to organize and equip a suitable laboratory of biology and hygiene which, in the opinion of the Board which we represent, is absolutely essential to the best interests of the people of this State for their preservation and well-being."[22] When called upon, Dr. Vaughan declared, "There is needed some place where every health officer of a town, village or city can have samples of drinking water or articles of food tested for impurities, and adulterations. . . . Then this laboratory should be made an educational center in hygienic subjects. The results of the work done in it should, through the State Board of Health, be made known to the people. There should also be carried on in such a laboratory original investigations concerning the causation, nature and prevention of disease. . . . Again, the instruction offered by such a laboratory to its students will make them fit advisers in all sanitary matters to the various communities in which they live."[23] Dr. Baker likewise emphasized the importance of laboratory work as an aid in teaching sanitary science: "It is not an untried experiment. It is a proposition to give proper room, opportunity and support to a laboratory which has already made contributions of incalculable value for the promotion of human welfare."[24] At the conclusion of these remarks by the members of the State Board of Health, the Regents of the University gave their hearty endorsement to the project.

Meanwhile the State Board of Health had petitioned the legislature as follows:

> To the Honorable, the Senate and House of Representatives of the State of Michigan:
>
> Your memorialists, the members of the State Board of Health, respectfully represent that:
>
> Whereas, The highest education and that of most use, is that which best fits mankind for right living, that which tends directly to the preservation of life, and to the perfection of physical and mental health and strength; and
>
> Whereas, The teaching of such "knowledge of most worth" at the University of Michigan is not yet well provided for; therefore,
>
> Resolved, That we earnestly memorialize your honorable bodies to take such action as shall lead to the maintenance of a well-equipped laboratory of hygiene at the University of Michigan, and of such instruction in sanitary science at the institution, as shall place that subject on a plane not inferior to that of any other subject taught at the University.[25]

On October, 1887, the legislature granted part of the amount asked for building and equipping a laboratory of hygiene.

Dr. Vaughan and his assistant, Mr. F. G. Novy, began their work using rooms and apparatus belonging to the chemical laboratory.[26] Not until October, 1888, however, was the new laboratory for the department of hygiene ready for occupancy. This was the first of its kind in the United States and the second of its kind in the world, the first being the Imperial Laboratory of Hygiene at Berlin.[27] In commenting on the development of the laboratory, Dr. Baker said afterwards during one of the regular meetings of the Board, "The proposition to maintain such a laboratory at the University . . . has come about because of the recent valuable work done in the present imperfect laboratory at the University."[28]

[20] Ibid., XV, xxxvi; ibid., p. 1.
[21] Ibid., p. xxxix.
[22] Ibid., p. xl.
[23] Ibid., p. xlii.
[24] Ibid., p. xliii.
[25] Ibid., p. xlv.
[26] Ibid., p. 1. one of Prof. Novy's first accomplishments was the exposure of the stenocarpine fraud. Advertised as a harmless remedy, Prof. Novy showed that it contained a dangerous amount of cocaine. (Ibid., p. 20.)
[27] Burr, op. cit., I (1930), 808.
[28] An. Rep. S.B.H., XV, xliv.

Protein Metabolism and Resistance to Infection

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The relationship between undernutrition associated particularly with protein deficiency and increased susceptibility to infectious disease will be discussed. Evidence will be presented showing that hypoproteinemia is frequently associated with intercurrent infections. Discussion is directed at the problem of the relationship of protein intake to the building up of the protein reserves and to the acquisition of immunity, the fabrication of antibodies and their role in preventing or resisting the development of intercurrent infections.

■ THE prevalence of widespread starvation as an accompaniment of total war represents not only an economic but also a medical problem, because, when severe food shortage becomes extensive, a rising death rate from infectious disease invariably follows. It is important, therefore, to discover the causes for this close relationship between war, famine and pestilence[5] in order that, with a better understanding of these causes, more adequate methods may be found to eliminate or control them. One does not have to go to Greece or Poland in order to study starvation; our hospitals and morgues are filled daily with its victims and afford a constant opportunity to observe its pathologic aspects. Prolonged starvation manifests itself similarly whether due to famine or to a variety of naturally occurring maladies. Thus, starvation may complicate such diseases as pyloric or esophageal carcinoma, ulcerative colitis, glomerulonephritis, nephrosis, cirrhosis of the liver, and, in fact, any type of chronic disease in which either the absorption or assimilation of food is seriously impaired. But no matter what the cause of undernutrition may be, its inevitable consequence is the gradual disappearance of the food reserves of carbohydrate, fat and protein, of minerals and vitamins, which have been stored in various tissues. The victim loses weight and strength until, eventually, the combination of anemia, cachexia and terminal infection brings the downhill process to an end.

This striking loss of resistance seen terminally is one of starvation's most conspicuous features, and until we ascertain the reasons for this loss our efforts to find a remedy will continue to be of little avail. I wish, therefore, this afternoon to point out certain facts secured both from postmortem and experimental observations which help to elucidate the general problem of protein metabolism and resistance to infection.

In a series of patients dying from various types of chronic disease hypoproteinemia was one of the outstanding clinical findings. Among these hypoproteinemic patients, moreover, the high incidence and severity of terminal infections was particularly noteworthy. For example, in those with total protein values of approximately 5 grams per cent or less, a serious infection in most instances dominated the terminal days of life (Table I). The simultaneous occurrence of hypoproteinemia and increased susceptibility to infection suggests the possibility of a mutual relationship.

A decrease in concentration of blood proteins may occur for several reasons. For example, it may be due to a loss of protein in the urine or elsewhere, to an increased utilization for purposes of energy, or to an insufficient intake of dietary amino acids. At times, also, damage to the mechanism responsible for the formation of blood proteins may materially restrict their normal fabrication. But regardless of the pathogenesis of hypoproteinemia, the progressive lowering of the plasma protein concentration leads ultimately to nutritional edema, intercurrent or terminal sepsis and death.

A brief analysis of the cases summarized in Table I may help to clarify the subject further. For example, Cases 1 and 2 illustrate the consequence of severe proteinuria. The first case in particular reëmphasizes Leiter's statement[8] that "it is during the relapses into an active transudative stage that the justly dreaded complications of nephrosis are most likely to occur" and that "it is quite evident, therefore, that the vast majority of deaths in nephrosis may be attributed to infections of peritoneal, pleural or subcutaneous trans-

Read at the Third Post Graduate Conference on War Medicine, the Seventy-eighth Annual Session of the Michigan State Medical Society, Detroit, September 22, 1943.
This work was made possible by support from the John and Mary R. Markle Foundation, the National Live Stock and Meat Board, and the Douglas Smith Foundation for Medical Research.

udates by pneumococci or hemolytic streptococci, and to respiratory diseases varying in severity from bronchitis to lobar pneumonia." The same conditions doubtless apply to glomerulonephritis, as seen in Case 2. It is inevitable that the prolonged proteinuria of renal disease, with its accompanying hypoproteinemia, must lead eventually to a marked loss by the tissues of their protein stores. Although the loss of albumin may be so severe as to lead to an actual increase in the concentration of serum globulin, the so-called reversal of the albumin-globulin ratio, this fact is not inconsistent with the idea that there may at the same time be a definite loss by the tissues of their globulin stores as well. Inasmuch as serum globulin is derived from the tissue protein reserves, these must be constantly added to or else they will become seriously depleted. Case 3 illustrates a consequence of depletion of the protein reserves because of an inadequate intake of the proper kinds of food. This patient, a sixty-year-old man, developed a perforative appendicitis. After appendectomy he failed to improve; his wound disrupted and he lost ground quickly. Six days before death a total protein determination revealed a severe hypoproteinemia; death resulted from a massive confluent bronchopneumonia. Later it was learned that for the six months prior to his final illness he had lived almost entirely on fruit juices and raw carrots. This low-protein diet was taken on the advice of a physician for treatment of an arthritis of the hands. It should be recalled that carrots, which contain approximately 1 per cent of protein, were first used by Kohman[7] as the source of protein for the production of experimental nutritional edema. The other cases illustrate the effects of obstructive lesions of the gastro-intestinal tract, and of other diseases upon the blood protein concentration. They all emphasize the fact that, as starvation and cachexia become more conspicuous, less and less dietary protein becomes available for replenishment of the reserves of albumin and globulin in their usual places of tissue-storage. Some of the surgical conditions cited point to the probability that if a greater preoperative effort were made to rebuild the protein reserves, the fatality rate from postoperative infections might be still further reduced. Finally, in malignancies, such as leukemia, lymphosarcoma and the like, diversion of dietary amino acids to the rapidly growing neoplastic cells may lead gradually to depletion of the protein reserves, followed ultimately by anemia, cachexia, nutritional edema, sepsis and death.

Consideration of these few illustrative cases makes it evident that, although the loss of reserves of carbohydrate, fat, minerals and vitamins may lead to serious consequences, it is the loss of protein that is particularly menacing. Proteins furnish the basic materials essential for the development of immunity, and especially for the creation of the antibody mechanism. The recent demonstrations that antibodies are proteins open up a new approach to the more complete understanding of infectious disease. The antibody mechanism is unquestionably the keystone of the structure of acquired immunity, and in time of famine it is the loss of immunity which leads inexorably to epidemic disease and general pestilence. One need only look at occupied Europe to see how undernutrition, war edema and mounting death rates are all part of a common pattern of infectious disease. But in order to comprehend this pattern better we must learn more about the relationship of protein metabolism to antibody production and to the acquisition of resistance.[3,4]

It has recently become apparent that protein metabolism in the adult organism in nitrogen equilibrium can no longer be thought of as a static process in which most of the ingested protein is excreted as urea and only a small portion, the so-called "wear and tear" quota, is replaced. On the other hand several groups of investigators[1,9,10,11] have shown that the exchange of nitrogen between the blood and tissues is an extremely dynamic process which goes on continuously. It is now certain, moreover, that the tissue reserves of protein serve as a medium of nitrogen exchange and are in a state of "dynamic equilibrium"[9] with the plasma proteins.

Although hitherto more interest has been manifested in the problem of formation of serum albumin and the consequences of its loss than in that of globulin metabolism, it is the latter problem, especially that of globulin formation, utilization and tissue-maintenance, that demands attention when considering the phenomena of acquired immunity. With the recent demonstrations that an antibody molecule is actually a molecule of normal globulin which, during synthesis, has been specifically modified, both the processes of production of normal and of antibody globulin become identical. Furthermore, in view of experimental evidence[9] that serum globulin is fab-

TABLE I. RELATIONSHIP OF HYPOPROTEINEMIA TO TERMINAL INFECTIONS

Case	Age (Years)	Sex	Total Protein Grams %	Interval Before Death	Clinical Diagnosis	Terminal Findings and Remarks
1 (3114)	3½	M	3.7	2	Nephrosis	Pneumococcic pleuritis; pneumococcic peritonitis
2 (5848)	35	M	3.8	10	Glomerulonephritis	Pneumococcic bronchopneumonia; acute pleuritis; acute peritonitis and septicemia
3 (5899)	60	M	4.2	6	Coronary occlusion	Acute confluent bronchopneumonia; acute pleuritis; acute peritonitis; acute purulent bronchitis; wound disruption (fruit juice and raw carrot diet for six months); marked emaciation
4 (4594)	63	F	4.0	10	Hypertension Diabetes	Bronchopneumonia; Urinary tract infection; purulent bronchitis; tuberculous cavity in lung
5 (5877)	51	M	4.1	1	Carcinoma of colon (postoperative)	Extreme emaciation; acute bronchopneumonia and pleuritis; acute peritonitis; early suppurative pyonephrosis
6 (5701)	57	F	4.9	7	Thrombophlebitis	Bronchopneumonia; fibropurulent pleuritis; purulent peritonitis; pyemia; acute renal infection; pulmonary abscesses
7 (5258)	44	M	5.2	0	Lymphosarcoma	Extreme emaciation; aspirative bronchopneumonia; lung abscess; active tuberculosis of hilar lymph nodes; urinary tract infection; serous atrophy of fat
8 (5183)	26	M	5.0	18	Carcinoma of stomach (Inoperable)	Marked emaciation; serous atrophy of fat; bronchopneumonia; serofibrinous pleuritis; peritonitis
9 (5097)	5	M	3.5	0	Glomerulonephritis	Acute bronchopneumonia; acute fibrinous pleuritis; peritonitis (staphylococcic); acute pyelonephritis
10 (4977)	20	M	4.3	9	Ulcerative colitis	Marked emaciation; acute bronchopneumonia; acute peritonitis; purulent bronchitis
11 (4666)	15	M	4.9	3	Pott's disease	Marked emaciation; serous atrophy of fat; generalized miliary tuberculosis; tuberculous pericarditis; tuberculous peritonitis
12 (4545)	26	M	4.3	2	Rheumatic heart disease	Emaciation; acute hemorrhagic bronchopneumonia; lung abscess; acute tracheobronchitis; acute pneumococcic septicemia
13 (5780)	26	M	3.7	3	Rheumatoid arthritis Amyloidosis	Extreme emaciation; amyloidosis; acute bronchopneumonia; acute pleuritis; pyemia; serous atrophy of fat; acute osteomyelitis
14 (5926)	45	M	3.4	16	Sprue (non-tropical)	Marked emaciation; serous atrophy of epicardial fat; acute bronchopneumonia; acute peritonitis; acute ulcerations of gastro-intestinal tract
15 (2313)	24	F	5.19	6	Acute yellow atrophy of liver	Acute confluent bronchopneumonia; acute cystitis; purulent bronchitis

ricated from protein constituents of the food, it is obvious that antibody production must also require an adequate supply of amino acids. Amino acid analysis has shown the presence in serum globulin of at least fourteen amino acids, of which seven are essential for the growth of rats (leucine and isoleucine, phenylalanine, tryptophane, arginine, histidine, and lysine).[2] Inasmuch as an essential amino acid is one that cannot be readily synthesized, it becomes evident that, both for the synthesis of normal globulin and antibody globulin, a wide assortment of amino acids must be available in the food.

Evidence that this is so is derived, also, from the following experimental facts: (1) Animals made hypoproteinemic by a prolonged low protein diet but adequate in calories, minerals and vitamins, are definitely more susceptible to spontaneous infections;[7,9] (2) animals so managed (rabbits and rats) undergo a marked loss of capacity to fabricate specific antibodies of several kinds (agglutinins, precipitins, hemolysins;[6] (3) rabbits, if subjected to prolonged protein depletion and then vaccinated against a virulent strain of pneumococci are unable to withstand infective doses of living pneumococci which are largely innocuous to well-nourished rabbits similarly immunized and infected (Wissler, unpublished experiments).

These experimental facts thus furnish an explanation for the profound loss of resistance in starvation, viz., that as starving patients become hypoproteinemic, the loss of their protein reserves makes them less able to respond to infections which in normal conditions could be well borne. This loss of acquired resistance may be due either to a loss of the antibody mechanisms built up because of previous infections, to the loss of globulin reserves during the developing hypoproteinemia, or to the inability in time of need to build antibodies quickly and of good quality and thus ward off an infection that would ordinarily be harmless. Furthermore, in the course of depletion of the protein reserves, the bone marrow also suffers cellular depletion, as seen in the condition known as "gelatinous degeneration." Under such a circumstance a reserve of leukocytes adequate for a limited time may still be inadequate to furnish phagocytic cells continuously in the presence of a developing infection which is increasing both in extent and severity. Due, therefore, to the loss of tissue food reserves, including protein, vitamins and probably other food elements as well, exhaustion of the bone marrow may in time be followed by leukopenia and terminal sepsis.

In conclusion, these cases and the accompanying experimental data have been presented because, as mentioned earlier, we cannot prevent these fatal types of infection until we know why they develop. If the fault lies in the loss of acquired immunity, an accelerated intake of protein of good quality may supply the building stones essential for the preservation or augmentation of acquired resistance. Rebuilding of the protein reserves would seem to be especially important in protein-depleted patients about to undergo serious operative procedures. But of vaster import is the indication that, for starving people entering the danger zones of hypoproteinemia, every effort should be made to rebuild the protein reserves as quickly and as completely as possible. If, in doing so, nitrogenous nutriment tends to restore the integrity of the antibody mechanism and of the phagocytic cells forming in the bone marrow, both the processes of acquired immunity and of natural resistance should function more effectively.

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MSMS

MUD AND GANGRENE

The mud of Italy increases the incidence of gangrene among soldiers. Men in desert warfare showed only three in each thousand afflicted by this condition, but in Italy the number has been raised to twenty per thousand. Special field laboratories have been set up there to develop more effective serums.—R. N. in *W. Va. Medical Journal,* March, 1944.

MSMS Committees

As your President, I feel that a few words of commendation are due the chairmen and members of the various standing committees of the State Society for their untiring efforts to make the practice of medicine in Michigan outstanding in these United States.

During the recent special session of our Legislature, the Legislative Committee, under the chairmanship of Dr. Harold A. Miller, was concerned with several important measures of interest to the medical profession. These bills are listed elsewhere in THE JOURNAL.

One of the outstanding accomplishments this year has been the publication and distribution to all members of the State Society of the "Cancer Manual." Dr. William A. Hyland and his committee and all of the physicians and surgeons who have contributed to this Manual are entitled to the highest praise and surely have the appreciation of all the Doctors of Medicine.

Last year, the Postgraduate Industrial Medical and Surgical Conference, sponsored by the Committee on Industrial Health, was so successful that this year Dr. K. E. Markuson and his committee have again given us a good example of what an active committee can do.

Since its beginning several years ago, the Committee on Distribution of Medical Care has been most active, but in the past year, when there has been so much ado about socialized medicine, Dr. R. L. Novy and his committee have had a real job and they are playing a most important part in providing information relative to the present status of distribution of medical care.

The Committee on Procurement and Assignment Service of Doctors of Medicine is doing a real job. Dr. Paul R. Urmston and his committee have worked untiringly, and it is really too bad that at times they should be bitterly attacked by some who are disgruntled. They have a job to do, and they are really doing it.

Postgraduate Medical Education in Michigan is not only outstanding but has set an example for many other states to follow. Under the chairmanship of Dr. J. D. Bruce and vice chairmanship of Dr. H. H. Cummings and their committee, the doctors of Michigan can be assured that postgraduate medical education in the postwar period will be even greater than at present.

All of the committees of the State Society are active and doing excellent work. I regret that I cannot mention and commend each committee. I hope I may do so in a future issue of THE JOURNAL.

In closing, watch Dr. Fred R. Reed's Public Relations Committee and coöperate with them in the work they are doing. Recently they had a very enthusiastic meeting and I am sure they are going a long way in public relations.

C. R. Keyport

President, Michigan State Medical Society.



President's Page

ANNUAL MICHIGAN POSTGRADUATE PROGRAM FOR GRADUATES IN MEDICINE

The Michigan State Medical Society, in coöperation with the University of Michigan Medical School, Wayne University College of Medicine, the Michigan Department of Health, and the Wayne County Medical Society, announces the postgraduate courses for 1944.

INTRAMURAL COURSES

All Dates Inclusive

Anatomy	(Thursdays) March 9-June 29
Care and Treatment of Children, Recent Advances in	May 15, 16 and 17
Common Problems in Differential Diagnosis	May 15, 16 and 17
Diseases of the Blood and Blood-forming Organs	May 1-5
Diseases of the Heart	May 25, 26 and 27
Electrocardiographic Diagnosis	Nov. 6-11
Gastroenterology	May 22, 23 and 24
Laboratory Diagnosis, Clinical	April 24-28
Ophthalmology and Otolaryngology	April 20-26
Personal Courses	Throughout the year
Roentgenology	April 17-21
Therapeutics, Recent Advances	May 18, 19 and 20
Summer Session Courses	July 3-August 25

EXTRAMURAL COURSES

Ann Arbor	April 11, May 9
Bay City	March 8, April 12
Flint	April 11 and 25
Grand Rapids	April 11, May 9
Jackson	April 4 and 26
Kalamazoo	April 27, May 16
Mt. Clemens	April 12 and 26
Traverse City	April 12, May 10

Subjects

Common Endocrinological Problems.

Deviation from the Normal in Developing Children. Practical Points in Everyday Pediatrics.

Treatment of Varicose Veins.

The Problem of Abortion. Classification. Rh Factor.

Relation of Physical Findings in the Chest to the Roentgen Findings. Panel Discussion.

Recent Developments in Gastroenterology. Panel Discussion.

UPPER PENINSULA

Monday, May 22—Sault Ste. Marie, Ojibway Hotel.

Tuesday, May 23—Marquette, Northern Michigan Children's Clinic.

Wednesday, May 24—Houghton, Douglass House.

Thursday, May 25—Ironwood, St. James Hotel.

Friday, May 26—Powers, Pinecrest Sanatorium.

Program

2:30 P.M.

The interpretation of clinical laboratory procedures useful in practice—Frank H. Bethell, M.D.

The modern management of varicose veins, phlebothrombosis, and thrombophlebitis—Robert W. Buxton, M.D.

Management of venereal diseases—Robert S. Breakey, M.D.

Deviation from the normal in developing children. Practical points in everyday pediatrics—Mark Osterlin, M.D.

6:15 P.M. Dinner.

Panel Discussions.

1. Management of blood diseases. Indications for transfusion.
2. Application of developments in nutrition to general practice.

For further information, address **Committee on Postgraduate Education, Michigan State Medical Society, Room 2040, University Hospital, Ann Arbor, Michigan**

EDITORIAL

EMIC

■ Acting upon the instructions of the 1943 Michigan State Medical Society House of Delegates, the Council and its Executive Committee have been endeavoring to obtain certain modifications of the bureaucratic orders governing the distribution of care under the Emergency Maternity and Infant Care program. Negotiations have been in progress for a considerable time, (since May 2, 1943), and the latest report at the Executive Committee meeting February 24, 1944, was an opinion from the solicitor of the U. S. Children's Bureau in answer to "your request for authority to reject the proposal." To an observer up a tree it would seem that an attempt to find some way to grant something to the medical profession might be tried at least once, to secure the doctors' full coöperation. Naturally, the Solicitor to the Children's Bureau found legal objections to give the Bureau official what he asked for—*Authority to reject Michigan's plan,* so the answer, thus far, to any modification of EMIC is NO.

CONTRIBUTIONS TO MSMS FOUNDATION FOR POSTGRADUATE MEDICAL EDUCATION

■ Michigan has had vision. In this state Postgraduate Medical Education has probably received more active attention than in most others. A large percentage of our members has received certificates of postgraduate accomplishments from the Michigan State Medical Society in the past several years. A Foundation to carry on this work has been established by the State Society as reported last year. This Foundation will soon have an opportunity to help in a very real problem—the reëstablishment of our service members after the war. That is a task that may overtax our Medical Schools because of increased numbers of students and disrupted teaching personnel. If it has the necessary funds, the Michigan State Medical Society will be prepared and in position to render yeoman service.

One of our doctors who wishes to remain anonymous has made a contribution of $100.00. This was accepted by The Council at its January meeting and a letter of thanks authorized. We believe there are many of our members and friends willing to do the same if their attention is called to it. Two contributions have now been acknowledged since the original gift which was used to set up the Foundation.

Our members may make donations to this Foundation now and get credit for approximately twice the actual cost. One can make donations up to fifteen per cent of net income before exemptions, and the tax on these amounts for individuals will be nearly fifty per cent. Therefore donations will actually cost not much over fifty per cent of the face value.

The need is apparent, the time is fast approaching, and to succeed we must be ready. Small contributions from many will fill the need and forearm us for the immediate future. Doctors, may we count on you?

REGIMENTED CONTROL

■ An article in the public press of February 23, 1944, casts an illuminating preview of bureaucratic medicine. The Mayor of Detroit, upon pressure from Rep. Dingell, canceled the membership of certain of the Detroit hospitals in the American Hospital Association because the Association is asking increased dues allegedly to fight the Wagner-Murray-Dingell Bill, and these hospitals being public institutions would be contributing to defeat the legislative efforts of one of Detroit's Congressmen. These hospitals are ordered not to pay dues to the American Hospital Association. Under the same philosophy any doctor could be ordered not to pay dues to the Medical Society of his choice, once he is regimented.

PLANS FOR THE FUTURE

■ It is reasonable to predict that the present Wagner Bill will not pass as now constituted. Too much opposition has developed. That reminds us of the first Wagner bill, and the opposition to it which blocked its passage. These two Wagner bills are not all the threats toward socialized, or regimented medicine. There have been many others, bills in Congress and other ac-

tivities, such as the Supreme Court decision, and gradual encroachment, such as the Emergency Maternity and Infant Care scheme put across in recent months by the U. S. Children's Bureau.

These threats are a carefully planned and well managed wearing down of our defenses. There will be more. In fact there has already been an indication of more in the President's new Bill of Rights. (Among our newly expressed rights are "the right to adequate medical and health service.") No one denies the desirability of such services, and the right every individual should have to secure those benefits. That right always has been ours, the same as the right to adequate housing, and adequate income (the lack of which are root causes of ordinary sickness).

The bureaucrats are still planning, and they may prevail ultimately for their vision is long, and they are eternally nudging toward their objective. Congressman Walter H. Judd, M.D., of Minnesota told the National Conference on Medical Services in Chicago on February 13, 1944, that we will lose the next fight unless we have some constructive proposal to offer. To obtain its wants the public is blindly drifting or purposefully driving toward the complete regimentation of Medicine.

The two great labor organizations have endorsed the Wagner-Murray-Dingell Bill, claiming to see in it a method of securing the medical and health services they wish for their people. Some of their intelligent leaders can see that the plan as now written will be inadequate to their needs. They say medicine is one of the most powerful unions, and they are not worrying about the doctors who "are able to look after themselves."

Suppose this labor argument be true, *how* are we to look after the interests of the whole population, and of the medical profession, unless we can offer something the labor leaders will accept, something that will supply their wants, something that is better than Wagner, Murray, or Dingell now offer. Labor argues that under their plan employment will pay half, and should pay at least that, but under private management and voluntary plans the laborer will pay the whole shot. Bureaucratic threats of regimentation and the fact that the cost under individual effort will be much less are not sufficient argument. The fact that management will pass along its costs to the consumer seems to have escaped the thinking of the labor leaders.

Defeat of the Wagner-Murray-Dingell Bill will not dispose of the dominating issues involved in the providing of medical care to the masses of the people.

Michigan has proposed Michigan Medical Service and Michigan Hospital Service. Some of our own members have opposed that. Organized labor wants still more than is now provided from whatever plan is offered. With full coöperation Michigan Medical Service could offer that more. Complete coverage was at first planned, and that is a goal to which Michigan Medical Service is aiming. This was a new venture with no rules and no beaten path. We tried to walk too soon, but made a magnificent attempt. We have now learned to walk, and the vision of our goal is getting clearer.

Do we in Michigan have the solution asked for by Doctor Judd? He said we will never again have such an opportunity. The next time the visionaries will put across their plans. We have failed miserably in publicizing our position, our resources, and our ideals. We have opposed rather than offered constructive advice. Let us not completely muff the chance.

The finest public relations for the medical profession would be to devise and put into effect some plan that would pull the teeth of such as Wagner, Murray and Dingell. We have the ability. We have the chance to sell our wares. Let us establish such centers of information—right in Washington, D. C., and in every State, City, Town and Hamlet in the nation—that we will never again be caught napping.

NATIONAL SURVEY ON MEDICAL SERVICES

▪ The National Physicians Committee on March 8, 1944, released a survey which was completed March first, made by the largest opinion research group in the country and has been in progress since July.

The survey is long and replete with tabulations of replies to several searching questions. The report indicates the necessity for more education of the public regarding the issues involved in proposals for changing the nature of medical service. When people understand the issues, an overwhelming majority are unqualifiedly opposed to any such proposals as the Wagner-Murray-

Dingell Bill, which would establish federal control of medical practice.

This report is available through the National Physician's Committee and our members should study it. The results are a challenge to medical leadership.

BAR ASSOCIATION CONDEMNS S1161

■ *The Journal of the American Medical Association,* for March 11 published the report of a committee from the American Bar Association on the Wagner-Murray-Dingell Bill: This proposal, they say, would inevitably produce communistic Medicine in the United States. The report criticizes the proposed legislation as adhearing to a "form of legislation full of involvement, terminology, percentages and other confusing matters," so the reader is at a loss to understand. "No one can estimate how much tax money is involved or how many people are covered from the face of the bill," so they made extensive studies and as a result unqualifiedly condemned the measure.

Senator Wagner is taken to task for statements made in introducing the bill of which they list twelve as incorrect.

The report should be carefully read. Its last paragraph reads:

"The Constitution of the United States is designed to protect the citizens of this republic in the exercise of the rights of free men. The provisions of that instrument can be rendered impotent when our citizens, for the sake of an apparent immediate benefit, surrender to their government such direct control over their lives that government, by imposing a constant fear upon them of having those benefits withheld or withdrawn, can compel from them obedience and subservience to its dictates."

THE SUCCESS OF MICHIGAN MEDICAL SERVICE

■ Good news to Michigan's medical profession is contained this month in the announcement that Michigan Medical Service now is "in the black."

Not only has the organization been on a paying basis for a year and a half, but it has overcome a deficit which at one time threatened dissolution of the entire program.

The Medical Service has just completed its fourth year of operation. The group support which has been given to it by Michigan doctors, despite early reverses which could easily have been fatal, now is proved justified. Moreover, Michigan Medical Service today constitutes the nation's outstanding demonstration of the practical success which can be achieved by medical service prepayment programs sponsored by the medical profession itself.

CORRESPONDENCE

To the Editor:

The general oral and pathology examinations (Part II) for all candidates will be conducted at Pittsburgh, Pennsylvania, by the entire Board from Wednesday, June 7, through Tuesday, June 13, 1944. The Hotel William Penn in Pittsburgh will be the headquarters for the Board. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examination dates. Hotel reservations may be made by writing direct to the Hotel.

Candidates for reëxamination in Part II must make written application to the Secretary's Office not later than April 15, 1944.

The Pittsburgh Obstetrical and Gynecological Society will hold an informal subscription dinner meeting at the Hotel William Penn, on Saturday evening, June 10, 1944, at 7:00 P.M. Visitors, here for the examinations, are cordially invited to make arrangements to attend. Reservations may be made by writing to Dr. Joseph A. Hepp, Secretary, at 121 University Place, Pittsburgh 13, Penna. An interesting program is being provided.

The Office of the Surgeon-General (U. S. Army) has issued instructions that men in Service, eligible for Board examinations, be encouraged to apply and that they may request orders to Detached Duty for the purpose of taking these examinations whenever possible.

Candidates in Military or Naval Service are requested to keep the Secretary's Office informed of any change in address.

Deferment without time penalty under a waiver of our published regulations applying to civilian candidates, will be granted if a candidate in Service finds it impossible to proceed with the examinations of the Board.

Applications are now being received for the 1945 examinations. For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

PAUL TITUS, Secretary

American Board of Obstetrics and Gynecology, Inc.
Feb. 18, 1944

SECOND MEETING

Friday, January 28, 1:55 P.M.

(Continued from March issue)

11. *Procurement & Assignment & Relocation of Physicians.* A letter from the Kalamazoo Chamber of Commerce deploring an alleged dearth of medical doctors in Kalamazoo was read and discussed. The Secretary was authorized to write Mr. Weber of the Chamber of Commerce concerning the work and scope of procurement and assignment service, with further information concerning the Relocation of Physicians Act recently passed by Congress. A copy of Mr. Weber's letter is to be sent to the Michigan P. & A. S. Chairman.

STATE HEALTH COMMISSIONER

12. *Consideration of political position having to do with health.* The Executive Secretary presented the background and contacts made in recommending the names of qualified doctors of Medicine to the Governor for the position of State Commissioner of Health. The matter was discussed by Drs. DeGurse-Stryker-Perkins-Keyport-Ledwidge-Umphrey-Haughey-Witwer-Riley-Brunk and Moore. A letter from Dr. E. V. Thiehoff was read.

Motion of Drs. Keyport-Riley that the names of all Doctors of Medicine proposed or who are known to be interested in this position be placed on a ballot and that the Councilors vote their choice, and that the choices be presented to the Governor in the order of their selection as first choice, second choice, etc. The motion was carried with two dissenting votes. The Councilors voted and the results of the ballot were announced by the Secretary.

Motion of Drs. Miller-Witwer that the Secretary be instructed to telegraph the Governor that "The Council of the Michigan State Medical Society in Annual Session in Detroit today voted to transmit for your consideration the following names for the position of State Commissioner of Health. These names are submitted in the order of the Councilors' preference after a secret ballot (followed by the list of seven names)." Carried unanimously. The Chair requested Dr. Witwer to procure from the Secretary a copy of this telegram so that he might make certain contacts to further this matter.

13. *M.S.M.S. representative to Vocational Rehabilitation Board.* R. C. Perkins, M.D., resigned this position, due to personal reasons. After some discussion, motion was made by Drs. Ledwidge-Stryker that the selection of a successor be referred to the Executive Committee for disposition. Carried unanimously.

(Recess for dinner, 5:05 p.m.)

THIRD MEETING

Friday, January 28, 8:45 P.M.

ANNUAL REPORT OF THE TREASURER

14. *Treasurer's Report.* Dr. Hyland answered to roll call, and presented the Annual Report to the Treasurer, as follows:

As Treasurer of the Michigan State Medical Society, I wish to submit the following report, to January 12, 1944, of the bonds and bond cash account in the General Fund of the Michigan State Medical Society:

Bond	Interest Rate	Date Due	Quoted Market Price 1/12/44
2 M American Telephone & Telegraph	3¼%	12/ 1/66	2,170.00
1 M Gov't. Dominion of Canada	3	1/15/67	1,017.50
2 M Canadian Pacific Railroad	4	Perpetual	1,735.00
2 M New York Central Railroad	4	2/ 1/98	1,270.00
1 M Consolidated Oil Corporation	3½	6/ 1/51	1,050.00
1 M Consumers Power Company	3¼	11/ 1/66	1,080.00
2 M Detroit Edison	3½	9/ 1/66	2,215.00
1 M Union Pacific Railroad	3½	10/ 1/70	1,040.00
1 M United Light & Power	5½	4/ 1/59	1,077.50
1 M Grand Rapids Affiliated	5	10/ 1/55	850.00
			13,505.00
Goverment Bonds carried at full value			12,500.00
			26,005.00

CASH ACCOUNT—GENERAL FUND:

Balance in General Fund Cash Account, September, 1943	$515.30
November 15, 1943, Deposit	86.25
	601.55
December 12, 1943, Deposit	50.00
	651.55
January 12, 1944, Deposit	55.00
Bank Balance January 12, 1944	$706.55

Motion of Drs. Hyland-Umphrey that the Treasurer's Report be approved. Carried unanimously.

ANNUAL REPORT OF THE TRUSTEE

15. *Annual Report of the Trustee.* Dr. Hyland presented the Trustee's report as follows:

As Trustee of the State Society, I desire to submit the following report, to January 12, 1944, of the bonds and bond cash account held in trust for the Michigan State Medical Society:

Bond	Interest Rate	Date Due	Quoted Market Price 1/12/44
2 M New England Gas and Electric	5 %	5/ 1/50	1,495.00
2 M Southern Pacific R. R.	4½	3/ 1/77	1,440.00
1 M Grand Rapids Affiliated	5	10/ 1/55	850.00
Total			3,785.00

CASH ACCOUNT—TRUSTEE FUND:

Balance in Trustee Fund Cash Account, September 5, 1943	$447.92
November 15, 1943, Deposit	75.00
	522.92
January 6, 1944, Check to Douglas, Barbour, Desenberg and Purdy (Facer vs. S. L. Lewis)	150.00
Bank Balance January 12, 1944	$372.92

Motion of Drs. Hyland-Umphrey that the Trustee's Report be approved. Carried unanimously.

REFERENCE COMMITTEE REPORTS

16. *Reference Report of County Societies Committee* was presented by Chairman Sladek, as follows:

1. Your committee met on January 28, 5:10 p.m. in the Book-Cadillac Hotel, and studied the following matters presented to it by The Council:

(a) Annual report of the Secretary. It was the sense of the committee members that they especially approve of the Secretary's recommendation for the employment of a full-time public relations representative. Motion was made by Drs. Perkins-Riley that the annual report of the Secretary be approved and that the Sec-

retary be commended for the usual thoroughness in making up the report.

(b) Annual report of the Publication Committee.—The new policy in advertising was fully discussed. Motion of Drs. Hubbell-Perkins that the report be approved. Carried unanimously.

Respectfully submitted,

E. F. Sladek, M.D., *Chairman*
Wilfred Haughey, M.D.
R. J. Hubbell, M.D.
R. C. Perkins, M.D.
P. A. Riley, M.D.

Motion of Dr. Beck—seconded by several that the report be accepted, was carried unanimously.

17. *Reference Report of the Publication Committee* was presented by Chairman Morrish, as follows:

1. Your committee met on January 28, 5:10 p.m. in the Book-Cadillac Hotel, and studied the following matters presented to it by The Council:

(a) Annual report of the Editor. This was read and motion was made by Drs. Miller-Beck that the annual report of the Editor be approved and that the Editor be extended a vote of commendation for his outstanding work and accomplishments with the M.S.M.S. publication during the past year. Carried unanimously.

(b) Annual report of the Finance Committee. This report was studied item by item and one amendment was made.

Motion of Drs. Beck-Miller that the annual report of the Finance Committee as amended be approved. Carried unanimously.

Respectfully submitted,

R. S. Morrish, M.D., *Chairman*
O. O. Beck, M.D.
A. H. Miller, M.D.
E. R. Witwer, M.D.

The proposed Budget for 1944 was presented and discussed item by item.

BUDGET, M.S.M.S., 1944

Income	
3,400 Members @ $12 (dues)	$40,800.00
3,400 Members @ $10 (assessments)	34,000.00
	74,800.00
Less allocation to Journal ($1.50)	5,100.00
	$69,700.00
Interest	100.00
Miscellaneous	100.00
Net Income	$69,900.00
From Reserves	10,000.00
	$79.900.00
Appropriations:	
Administrative and General:	
Administrative Salaries	$11,600.00
Salaries: Office—regular	7,020.00
Salaries: Office—extra	200.00
Office Rent and Light	1,350.00
Printing, Stationery, Supplies	1,800.00
Postage	1,700.00
Insurance and Fid. Bonds	200.00
Auditing	400.00
New Equipment and Repairs	500.00
Telegraph and Telephone	800.00
Michigan Sales Tax	170.00
Payroll Taxes	125.00
Miscellaneous General Expense	150.00
	$26,015.00
Less Exp. Redistr. to Journal	1,800.00
Total Adm. and General	$24,215.00
Society Activities:	
Council Expense	$ 2,800.00
Delegates to A.M.A.	550.00
County Secy. Conferences	300.00
General Soc. Travel Exp.	1,500.00
Officers' Travel Exp.	1,300.00
Secretary's Letters	300.00
Publication Expense	150.00
Reporting Ann. Meet.	250.00
Public Education Expense	34,000.00
Nat. Conf. on Med. Serv.	200.00
Legal Expense	6,000.00
Woman's Aux.—Ann. Meet.	200.00
Commissions and Disc. (Booths)	50.00
Sundry Soc. Expenses	500.00
Total Society Expense	$48,100.00
Committee Expenses:	
Legislative	$ 385.00
Dist. of Med. Care	150.00
Joint Com. Health Education	500.00
P.G. Medical Education	3,500.00
Prev. Medicine	100.00
Cancer Control	500.00
Child Welfare	100.00
Iodized Salt	50.00
Heart and Deg. Diseases	50.00
Industrial Health and (Clinic)	700.00
Maternal Health	50.00
Mental Hygiene	50.00
Radio	100.00
V.D. Control	50.00
T.B. Control	50.00
Public Relations	50.00
Ethics	750.00
Scientific Work	50.00
P. and A. S. for M.D.'s	200.00
Prelic. Medical Edu.	50.00
Prof. Liaison	50.00
Sundry other Comms.	100.00
Total Committee Expense	$ 7,585.00
Grand Total	$79,900.00

BUDGET FOR THE JOURNAL, 1944

Income	
Subscriptions from members	$ 5,100.00
Other subscriptions	100.00
Advertising Sales	14,000.00
Reprint Sales	925.00
Journal Cuts	150.00
Total Journal Income	$20,275.00
Expenses	
Editor's Salary	$ 1,200.00
Editor's Expense	900.00
Printing and mailing	11,775.00
Cost of reprints and cuts	850.00
Discounts and Commissions on adv. sales	3,500.00
Allocation of Adm. and general office exp.	1,800.00
Postage	250.00
Total Journal Expense	$20,275.00

Chairman Umphrey of the Finance Committee explained the budgetary allotments and answered questions. He stated that the Public Educational Fund should be kept separate and distinct from the General M.S.M.S. Fund and a separate accounting should be made monthly and at the end of 1944. Dr. Moore stated that the accumulation of small reserves in the past has been justified as they are necessary when emergencies arise, as in the current year with 1137 members in military service. Motion of Drs. Perkins-Sladek that the report, including the Budget for 1944, be adopted. Carried unanimously.

18. *Reference Report of Finance Committee* was presented by Chairman Umphrey, as follows:

1. Your committee met on January 28, 5:10 p.m. in the Book-Cadillac Hotel, and studied the following matters presented to it by The Council:

(a) County Society Committee Report. Motion of Drs. Stryker-DeGurse that the report be approved with two corrections as follows:

(1) Item 4 changed from Joint Committee on Health Education to "Committee on Postgraduate Medical Education."

(2) Item 11 added: "in coöperation with L. A. Potter of the State Department of Health." Carried unanimously

(b) Obstetric-Pediatric Care Program (Report of Special Committee)—On motion, of Drs. Barstow-Stryker, the report of the Special Committee is approved with a further recommendation that a letter be sent by Michigan State Medical Society to the Board of Directors of Michigan Medical Service urging them to call a special meeting for the purpose of placing in operation the plan if and when approved by the United States Children's Bureau. Carried unanimously.

Respectfully submitted,

C. E. Umphrey, M.D., *Chairman*
W. E. Barstow, M.D.
T. E. DeGurse, M.D.
W. H. Huron, M.D.
O. D. Stryker, M.D.

Motion of Dr. Witwer—seconded by several that the report as presented be adopted. That portion of the report having to do with the Federal Program of Obstetric-Pediatric Care was discussed by Drs. Riley-Beck-Morrish-Ledwidge-Huron-Brunk-Keyport-Haughey-and Moore. Motion carried unanimously.

19. *Reference Report of Special Committee on Michigan Health Council.* Chairman Keyport reported that his committee concurred in Dr. Brunk's report (Item 10—h). He felt that Michigan Health Council appears to have developed a definite program and that M.S.M.S. should coöperate, but if the Council lacks a good program, the State Society should withdraw from participation. Motion of Dr. Keyport—seconded by several that the Report of the Reference Committee be adopted. Carried unanimously.

20. *Floyd E. Armstrong,* Professor of Economics at M.I.T., was introduced and made a few brief remarks expressing his pleasure at being invited to attend this meeting.

21. *Attorney General's Second Opinion* re persons licensed by the Laws of Michigan to prescribed drugs for internal human medication. The Council's attention was invited to this second Opinion, published on page 940, of the December, 1943, M.S.M.S. Journal, in which the Attorney General's opinion is to the effect that he has no opinion on this subject.

22. *National Conference on Medical Service,* Chicago, February 13, 1944. Motion of Drs. Barstow-Witwer that the President, the Council Chairman, the Editor, and the two Secretaries be authorized to attend this meeting. Carried unanimously.

SCHOOL OF INFORMATION

23. *"School of Information"* of January 30, 1944, Book Cadillac, Detroit. Secretary Foster reported on this meeting and its excellent program and urged the Councillors to attend the Session and lend their encouragement to the Conference.

24. *Letter from Wayne County Medical Society* re "What is Osteopathy," together with a letter from W. B. Cooksey, M.D. addressed to a Detroit osteopath, were read. The matter was discussed by Drs. Haughey-Foster-Barstow-Witwer-Ledwidge. Dr. Sladek read an extract from a Montana case. Statistics on basic science board examinations were presented by Secretary Foster. Dr. Keyport mentioned that the State Board of Registration in Medicine had uncovered a number of cases of interns in hospitals who had not passed the basic science board examination and felt that some osteopaths and chiropractors undoubtedly are practicing without having been certified by the basic science board. Dr. Umphrey felt that the down-river physicians in Wayne County should be informed that The Council believes they have some important information that should be worked up into usable cases. Motion of Drs. Huron-Perkins that action on this matter be taken as soon as expedient was carried unanimously.

Motion of Drs. Ledwidge-Huron that a letter be dispatched to the Wayne County Medical Society commending it on its activity and study of this increasingly great problem, urging it to continue its research, and advising that the M.S.M.S. Council is working on this matter, looking to an early solution. Motion carried.

25. *Michigan Juvenile Code.* The Executive Secretary reported on proposed amendments to the Michigan Juvenile Code and read extracts of some of the sections to be presented to the Legislature on January 31. The matter was thoroughly discussed and referred to the January 30 Conference.

The meeting was recessed at 11:10 p.m., the Chair thanking all for their good advice and help. He also thanked the pre-prandial hosts, Drs. Barstow-DeGurse-Perkins-Witwer, for their very potent contribution to the success of the session.

FOURTH MEETING

Saturday, January 29, 1944—10:30 A.M.

26. *Minutes.* The minutes of the first, second, and third meetings of The Council held January 28, were presented and approved on motion of Drs. Ledwidge-Miller. Carried unanimously.

RESOLUTION RE MICHIGAN MEDICAL SERVICE

27. *Brasie Resolution.* The Special Committee reported as follows:

Considerable correspondence and a number of conferences lead your committee to the following conclusions.

As of November 30, 1943, Michigan Medical Service shows a deficit of $236,000. Enforcement of the Brasie Resolution at this time would undoubtedly result in immediate cancellation of many or all group contracts. This would mean that Michigan Medical Service would be saddled with a large debt with no means of liquidating it. In this event, it would be the duty of the Commissioner of Insurance to assume control, eliminate the Board of Directors and continue the present policy. It is his opinion that legislative action must be taken to clarify a number of provisions in the Enabling Act.

The deficit is largely an estimated reserve for services rendered which have not been reported. If Michigan Medical Service ceases to do business it would mean a loss of a quarter million dollars to the doctors of Michigan.

Therefore, your committee recommends that no action be taken until such time as all indebtedness of Michigan Medical Service is liquidated.

Respectfully submitted,

E. F. Sladek, M.D., *Chairman*
O. O. Beck, M.D.
P. A. Riley, M.D.
E. R. Witwer, M.D.

Motion of Drs. Witwer-Barstow that the report be accepted and that résumé of same be published in the M.S.M.S. Journal. The report was discussed by Drs. Hubbell-Perkins-Beck-Haughey, and was carried unanimously. Chairman Moore commended the members for their work and excellent report.

ELECTIONS

28. *Elections:*

(a) *Secretary:* L. Fernald Foster, M.D., was

nominated for the position of Secretary of the Michigan State Medical Society for the ensuing year. Motion of Drs. Beck-Barstow that the nominations be closed and that a unanimous ballot be cast for Dr. Foster as Secretary. Carried unanimously. The ballot was so cast by the Acting Secretary.

(b) *Treasurer*: Wm. A. Hyland, M.D., was nominated for the position of Treasurer. Motion of Drs. Stryker-Morrish that the nominations be closed was carried unanimously. Motion of Drs. Ledwidge-Beck that the Secretary be instructed to cast a unanimous ballot for Dr. Hyland as Treasurer of the Michigan State Medical Society. Carried unanimously. The Secretary did so cast.

(c) *Editor of The Journal*: Wilfrid Haughey, M.D., was nominated as Editor of the M.S.M.S. JOURNAL. Motion of Drs. Umphrey-Ledwidge that the nominations be closed and the Secretary be instructed to cast a unanimous ballot for Dr. Haughey as Editor of the M.S.M.S. JOURNAL. Carried unanimously. The Secretary did so cast.

(d) Appointment of *Executive Secretary*: Wm. J. Burns was nominated as Executive Secretary of the Michigan State Medical Society by Drs. Barstow-Sladek. Motion of Drs. Beck-Hubbell that the nominations be closed and that Mr. Burns be appointed as Executive Secretary of the Michigan State Medical Society. Carried unanimously.

29. *Free Press Editorial.*—Motion of Drs. Umphrey-Beck that the *Detroit Free Press* be congratulated for the excellent editorial entitled "A Backward Step" and cartoon entitled "The Quack" which appeared in the issue of January 27, 1944. Carried unanimously.

30. *Report of individual Councilors on condition of profession in each District.* The Councilors individually reported on matters in their Districts which in the main were satisfactory, the problems, with few exceptions, being similar in all parts of the state. The double-duty work of all physicians on the home front was stressed by every Councilor.

CANCER MANUAL

31. *Cancer Manual.*—Motion of Drs. Witwer-Barstow that the M.S.M.S. Cancer Control Committee be extended a vote of thanks and commendation for its publication, in coöperation with the Michigan Department of Health, of the *Cancer Manual* which is being sent to every M.S.M.S. member with the compliments of the State Society. Carried unanimously.

32. *Medical Panel Plan for Michigan.*—The Secretary announced that Mr. L. J. Carey and Mr. Buchanan, insurance representatives to the proposed Medical Panel Plan, were desirous of arranging a meeting with the medical representatives, Drs. Beck and Foster, early in February, to begin definite considerations of this mutual project.

33. *More detailed minutes* of meetings of Executive Committee of The Council. Dr. Huron urged that the minutes of Executive Committee meetings be submitted in greater detail to the members of The Council. This was thoroughly discussed by Drs. Foster-Perkins-Barstow-Ledwidge-Brunk-Moore. Motion of Drs. Perkins-Barstow that in future, after the minutes of meetings of The Council and of its Executive Committee are edited and approved by The Chairman, that they be sent to all Councilors immediately. Carried unanimously. Any Councilor who wishes additional information on one or more items in the minutes may contact the Secretary or Executive Secretary by telephone.

(The meeting was recessed at 1:05 p.m.)

FIFTH MEETING

Saturday, January 29, 1944—1:50 P.M.

34. *Present* at this meeting, in addition to the Councilors, were Dean Edgar J. Norris of Wayne University College of Medicine, Attorney Thomas F. Chawke, and Past President Louis J. Hirschman, M.D., all of Detroit.

PSYCHIATRIC CLINIC

35. *Psychiatric Center* in connection with Wayne University College of Medicine. Dean Norris was invited to present the details of the proposed psychiatric clinic project. He stated that the Michigan State Hospital Commission had announced its postwar program for the care of psychiatric cases with an estimated expenditure of $17,000,000. This would include the erection of a 2,500 to 3,000 bed psychiatric hospital just outside Wayne County. A filter clinic is needed for diagnostic study and therapeutic care, and this could be placed on the campus of Wayne University College of Medicine for training purposes in study and research available to both faculty and students of the Medical School. Dean Norris felt that a program could be worked out with the State Hospital Commission whereby the control of the clinic would be dual and not exclusively under the State Hospital Commission. Dr. Ledwidge asked what guarantees have been given to Dr. Norris that the State Hospital Commission would change its policy of having paid employes (Drs. of Medicine) in this as well as in all its other institutions. Dr. Norris said there was no guarantee—only a gentleman's agreement. Wayne University will provide the teachers and research men to the institution while the State Hospital Commission will provide its functional personnel. Dr. Witwer asked about the financial and ultimate managerial arrangements: will there be a conflict between this proposed project and the industrial unit, and will the State Hospital Commission tie damaging strings to Dr. Norris' proposed arrangements? Dr. Norris felt that the best arrangements would be to have the State Hospital Commission place the hospital and clinic, integrated and built into the University Hospital, under the medical school. Dr. Umphrey listed the three conditions: (a) owned and operated by the State Hospital Commission; (b) board of education shall supply adequate teaching staff; (c) such teaching program shall be satisfactory to the State Hospital Commission. Other discussants were Drs. Perkins-Sladek-Moore. Dr. Umphrey thanked Dr. Norris for his attendance and his explanation of the details of this project. Chairman Moore stated that the Michigan State Medical Society and its Council members all are interested in developing a good medical center in Detroit and that medical school needs which are proper and sufficient should be obtained; he also thanked Dr. Norris for leaving a sick bed to be present at The Council meeting. After Dr. Norris had been excused from the meeting, the proposal of attaching a psychiatric clinic to Wayne University College of Medicine was discussed by Drs. Haughey-Umphrey-Witwer-Moore. The proposed purposes were amended by Dr. Umphrey, to read as follows:

The State Hospital Commission has considered the proposal of The Wayne University Medical Center that the State of Michigan make available to the Hospital Commission a sum of money for the purpose of building a psychiatric unit to be located on the campus of Wayne University. The Commission feels that the creation of a unit within the Detroit city area of approximately 200 beds to serve as a research center for mental cases, to give intensive therapy over a short period to acute cases and to operate an outpatient clinic, is a sound and desirable undertaking properly within the scope of the State Hospital Commission. The Commission also feels

that it is desirable to coöperate with educational institutions to aid in the establishing of an adequate training program of badly needed psychiatric personnel. Wayne University, an institution of higher education, proposes that such a psychiatric unit be located on the campus of the Wayne University Medical Center and that there be incorporated in such unit, proper facilities to facilitate the afore-mentioned training program and to make possible research and investigation in the field of mental difficulty. It is of course obvious that no adequate training or research program can be carried on by any educational institution unless it has convenient access to a facility in which sufficient clinical material is available and where a program of treatment and care exists. It is equally true that in the overall program of the State Hospital Commission in order to deal adequately with the total problem of the mentally afflicted there must be a clear accelerated program of personnel training, investigation and research.

The Hospital Commission believes that such an undertaking as has been suggested, is desirable providing the following points are incorporated:

1. That the psychiatric unit shall be operated and managed by the Wayne University School of Medicine.
2. That the Board of Education of the City of Detroit shall agree in advance to provide adequate fulltime teaching staff for the training of the various types of psychiatric personnel;
3. That an attempt shall be made to make such teaching program a type and of a curricular content satisfactory to the State Hospital Commission at all times.

Motion of Drs. Huron-Umphrey that the memorandum for Governor Kelly from the State Hospital Commission, as modified by The Council, be approved. Carried unanimously.

36. *Burns Case.*—Attorney Chawke reported on the legal aspects of this matter and answered questions by the Councilors. He was thanked by the Chair for his attendance.

37. *Adjournment.*—Chairman Moore thanked all Councilors for their attendance, forbearance and good advice. Motion of Drs. Umphrey-Ledwidge that Chairman Moore be congratulated for his excellent handling of the duties of his office during the stress of a difficult year. Carried unanimously. The meeting was adjourned at 3.15 p. m.

REPORT OF AUDITORS FOR 1943

We have examined the balance sheet of the Michigan State Medical Society as of December 31, 1943, and the statement of income and expense for the period from December 27, 1942, to December 31, 1943, have reviewed the system of internal control and the accounting procedures of the Society, and, without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence, by methods and to the extent we deemed appropriate. Our examination was made in accordance with generally accepted auditing standards applicable in the circumstances and included all procedures which we considered necessary.

The Society was organized on September 17, 1910, under the laws of the State of Michigan as a corporation not for pecuniary profit. The charter was extended on November 10, 1941, for a period of thirty years from September 17, 1940. The Society is affiliated with the American Medical Association and charters county medical societies within the State of Michigan. The purposes of the Society are the promotion of the science and art of medicine, the protection of the public health, and the betterment of the medical profession. In the furtherance of these purposes, the Society publishes THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY.

Balance Sheet

A summary of the balance sheet at December 31, 1943, follows:

ASSETS	*Dec. 31, 1943*
Cash	$27,517.90
Accounts receivable, less reserve	1,803.90
Securities—at cost	23,456.55
Postgraduate Medical Education Foundation	9,356.84
Deferred charges	120.05
	$62,255.24
LIABILITIES	
Accounts payable	$ 6,437.95
Unearned income	17,532.50
Reserves	9,644.84
Net worth	28,639.95
	$62,255.24

Income and Expense Statement

A summary of the income and expense statement for the period from December 27, 1942, to December 31, 1943, is presented, as follows:

	From Dec. 27, 1942 to Dec. 31, 1943
Income:	
Membership fees	$37,062.48
Income from THE JOURNAL	3,000.77
Interest received	978.78
Miscellaneous	40.69
TOTAL INCOME	$41,082.72
Expenses:	
Administrative and general	$23,947.04
Society activities	19,349.06
Committee expenses	8,174.88
TOTAL EXPENSES	$51,470.98
EXCESS OF INCOME OVER EXPENSES	$10,388.26
Other expenses	1,800.00
NET LOSS	$12,188.26

A comparison of the budget for the year 1943, adopted at the January meeting of the Council, with the actual results of operations for the year is presented in the following summary:

Accounts receivable for advertising, reprints, etc., were analyzed as to month of charge and are compared with a similar classification at December 26, 1942, as follows:

MONTH OF CHARGE	Amount	December 31-1943 Per cent
October, November, and December	$1,300.40	91.75%
July, August, and September	42.00	2.96
January to June, inclusive	75.00	5.29
Prior to January 1st		
TOTAL	$1,417.40	100.00%

Our examination of accounts receivable at December 31, 1943, included tests of the balances by communication with selected debtors. During the period, accounts receivable for advertising, reprints, etc., aggregating $58.00, and accounts receivable from county societies for dues, amounting to $58.58, were charged to the reserve for doubtful accounts. In our opinion, the reserve in the amount of $50.00 is sufficient to care for losses anticipated in the collection of the accounts.

The changes in securities during the period were as follows:

Balance at December 27, 1942	$ 31,674.78
ADDITIONS	
Securities purchased from William A. Hyland, trustee, at market price as of July 22, 1943: New York Central Railroad Company, 4% bond, maturing February 1, 1998	$ 633.75
Securities purchased from Michigan National Bank at price of issue as of September 14, 1943: United States of America Savings Bond, Series G, 2½ %, maturing September 1, 1955..	1,000.00

Increase in redemption value of United States of America Savings Bonds, acquired in prior years	203.30	1,837.05
		$ 33,511.83

DEDUCTIONS

Redemption of Government of the Dominion of Canada, 2½% bond, due August 15, 1945, called for payment on August 15, 1943	$ 991.25
Balance at December 31, 1943	$32,520.58

Represented by:	
Securities held by the Society	$ 23,456.55
Securities held by the trustee of the Postgraduate Medical Education Foundation	9,064.03
Balance at December 31, 1943	$32,520.58

Securities owned at December 31, 1943, have been stated at cost. In the course of our examination we inspected the securities and accounted for the income therefrom for the period. At December 31, 1943 aggregate market prices of securities held by the Society were $272.50 in excess of the cost thereof and aggregate market prices of securities held by the trustee of the Postgraduate Medical Education Foundation were $326.47 in excess of the cost thereof.

Waived Dues of Military Members

The Society has continued the policy of waiving payment of dues of members of the armed forces, and in the event the current year's dues were paid, to allow one year's membership without charge at the expiration of service. During the year, additional members have been reported to be in the services and an additional provision in the amount of $1,512.00 has been made to defer the income received from members reported to have entered service. A further provision amounting to $288.00 has been made for deferment of dues of members in the military services who have not been reported to the Society as being in service.

Opinion

In our opinion, the accompanying balance sheet and related statement of income and expense present fairly the position of Michigan State Medical Society at December 31, 1943, and the results of its operations for the period from December 27, 1942, to December 31, 1943, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding period.

ERNST & ERNST,
Certified Public Accountants

January 18, 1944

BALANCE SHEET

MICHIGAN STATE MEDICAL SOCIETY

December 31, 1943

ASSETS			
Cash			
Demand deposits		$ 3,698.49	
For deposit		1,078.00	
Office cash fund		1.59	
Savings deposits		22,739.82	$ 27,517.90
Accounts Receivable			
For advertising, reprints, etc.	$ 1,417.40		
Less reserve	50.00	$ 1,367.40	
From exhibitors, for space at 1944 annual meeting		399.00	
Miscellaneous		37.50	1,803.90
Securities			
Bonds, at cost			23,456.55
Postgraduate Medical Education Foundation			
Bonds, at cost		$ 9,064.03	
Cash		292.81	9,356.84
Michigan Medical Service			
Organizational expenditures made by Michigan State Medical Society		$ 17,544.45	
Less reserve		17,544.45	
Deferred Charges			
Expenses in connection with 1944 activities			120.05
			$ 62,255.24
LIABILITIES			
Accounts Payable			
For current expenses, etc.		$ 6,373.19	
Pay roll taxes		45.76	
Advertiser's deposit		19.00	$ 6,437.95
Unearned Income			
A. P. Biddle oration fund applicable to the year 1944		$ 100.00	
Sale of exhibitors' space at 1944 annual meeting		1,180.00	
Dues for the year 1944		2,440.50	
Dues of military members applicable to a future year		13,812.00	17,532.50
Reserves			
For deferment of dues paid by military members not reported		$ 288.00	
For Postgraduate Medical Education Foundation		9,356.84	9,644.84
Net Worth			
Balance at December 27, 1942		$ 40,153.21	
Add: Reimbursement for special legal fees of Postgraduate Foundation paid in a prior year		600.00	
Expenses in connection with 1942 annual meeting paid by State of Michigan, Health Department		75.00	
		$ 40,828.21	
Net loss for the period		12,188.26	28,639.95
			$ 62,255.24

INCOME AND EXPENSE STATEMENT
MICHIGAN STATE MEDICAL SOCIETY

From December 27, 1942, to December 31, 1943

Income:		
Membership fees	$ 42,357.00	
Less portion allocated to income of THE JOURNAL for subscriptions	5,294.52	$ 37,062.48
Income from THE JOURNAL—as shown by schedule		3,000.77
Interest:		
On securities	$ 715.80	
On savings deposits	262.98	978.78
Reduction of reserve for doubtful accounts		8.42
Miscellaneous		32.27
TOTAL INCOME		$ 41,082.72
Expenses—as shown by schedule:		
Administrative and general	$ 23,947.04	
Society activities	19,349.06	
Committee expenses	8,174.88	51,470.98
EXCESS OF EXPENSES OVER INCOME		$ 10,388.26
Other deduction:		
Provision for deferment of dues paid by military members		1,800.00
NET LOSS*		$ 12,188.26*

INCOME FROM "THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY"

From December 27, 1942, to December 31, 1943

Income:	Actual
Subscriptions from members	$ 5,294.52
Other subscriptions	158.00
Advertising sales	14,358.69
Reprint sales	921.52
Journal cuts	147.42
	$20,880.15
Expenses:	
Editor's salary	$ 1,200.00
Editor's expense	900.00
Printing and mailing	11,464.48
Cost of reprints	857.45
Discounts and commissions on advertising sales	1,407.45
Allocation of administrative and general expense	1,800.00
Postage	250.00
	$ 17,879.38
NET INCOME	$ 3,000.77

EXPENSES
MICHIGAN STATE MEDICAL SOCIETY

From December 27, 1942, to December 31, 1943

Administrative and general:	Actual
Administrative salaries	$ 11,600.00
Office salaries	6,294.63
Extra office help	221.38
Office rent and light	1,336.00
Printing, stationery, and supplies	2,955.28
Postage	1,414.45
Insurance and fidelity bonds	177.72
Auditing	380.00
New equipment and repairs	350.00
Telephone and telegraph	569.78
Michigan sales tax	145.35
Pay roll taxes	139.13
Miscellaneous	163.32
	$ 25,747.04
Less expenses redistributed to THE JOURNAL	1,800.00
	$ 23,947.04
Society activities:	
Council expense	$ 2,782.04
Delegates to American Medical Association	521.45
County secretaries' conferences	762.17
General society travel expense	1,504.55
Officers' travel expense	1,422.44
Secretary's letter	293.60
Publication expense	144.04
Reporting annual meeting	229.70
Secretary's expense	400.00
Educational expense	1,000.00
National Conference on Medical Service	156.85
Organizational expense	
Legal expense	10,758.60
Woman's Auxiliary—annual meeting	200.00
Sundry society expenses	552.67
	$ 20,728.11
Less revenue from annual meeting in excess of cost thereof	1,379.05
	$ 19,349.06
Committee expenses:	Actual
Legislative committee	$ 1,888.76
Distribution of medical care	164.41
Joint Committee on health education	526.50
Postgraduate medical education	2,978.24
Preventive medicine	58.25
Cancer	1,502.84
Child welfare	53.34
Iodized salt	
Heart and degenerative diseases	
Industrial health	378.59
Maternal health	22.37
Mental hygiene	27.17
Radio—Note A	105.00
Venereal disease control	69.74
Tuberculosis control	
Public relations	
Ethics	8.62
Scientific work	96.49
Procurement and assignment service of Doctors of Medicine	228.50
Prelicensure medical education	
Professional liaison	40.56
Sundry other committees	25.50
	$ 8,174.88
TOTAL	$ 51,470.98

STATEMENT OF TRUST BALANCE
WILLIAM A. HYLAND, TRUSTEE

From December 27, 1942, to December 31, 1943

Trust balance at December 27, 1942		$ 3,548.67
Additions:		
Interest income on bonds	$ 260.00	
Profit on sale of securities	106.25	
Increase in carrying amounts of securities held in trust at December 31, 1943, to cost	60.00	426.25
		$ 3,974.92
Deductions:		
Legal fees paid		402.00
Trust balance at December 31, 1943		$ 3,572.92
Represented by:		
Demand deposit—Michigan National Bank		$ 522.92
Securities—at cost		3,050.00
TOTAL		$ 3,572.92

YOU AND YOUR BUSINESS

WHY SPEED UP PREMEDICAL EDUCATION?

The first paper in the *Southern Medical Journal* for February, 1944, by Dr. Stanley E. Dorst, Dean of the University of Cincinnati College of Medicine, deals with the effects which eighteen months of the accelerated educational program has had on the faculty and students of medical schools. In common with virtually every other medical educator who has expressed himself, Dr. Dorst feels that the accelerated program is bound to result in an inferior quality of education. He deplores particularly the unnecessary speeding-up of premedical training, which allows students only fifteen to eighteen months to make the transition from high school to medical school. "One fears that these men may enter medical school inadequately prepared and stale from overwork. . . . I can see little reason for this speeding-up of the premedical program. Regardless of the tempo of medical education, the medical schools of the nation can accept only 7,500 students every nine months. . . . A more deliberate and thorough premedical training would in no way lessen the number of physicians to be graduated during the war years. Instead they would surely be better physicians and the loss because of failure would undoubtedly be appreciably smaller."

Dr. Dorst concludes his timely address with a plea for facing facts realistically. "Standards have already been lowered and they will continue to fall. . . . Let us accept the results of this devastating war and try to assay them critically, not ignore them."

Twelve of every hundred babies born in Michigan nowadays have fathers who are in the armed forces, according to the state health department. In reporting a total of 125,488 babies born in Michigan in 1943, the department calls attention to the fact that 11.6 per cent of all births for the year were to wives of servicemen and adds that the proportion of such births apparently is increasing. Unofficial totals for December, last year, show 12.9 per cent of all births were to servicemen's wives. Births in this classification, last year, totaled 14,532.

At the price now paid for EMIC services in Michigan this will cost the federal government $726,600.00 per year for Michigan alone.

We have bickered for years over plans for prepaid hospitalization and medical care. In some places the bickering ceased, plans were adopted, and in the majority of cases everyone seemed happy. But in other communities the bickering continued, no conclusions could be reached, no plans were adopted, and another finger of scorn was pointed in our direction. Out of this confusion arose the flames that kindled S. 1161; so out of the wells and rivers of justice must come the waters to extinguish the flame. Not by federal control, not by political bureaucrats, but by the united efforts of the medical profession and hospital boards, giving their best services to the low income group at a minimum rate, on a prepayment basis, with free choice of physician and hospital. We know this. We want this. Then, for heaven's sake, let's do it.—Robt. J. Reed, Jr., President W. Va. S.M. S., February, 1944.

* * *

During the past four years, there has been a rapid development of prepayment medical plans, operated on a non-profit basis and sponsored by the medical profession. At the present time such plans are operated in these thirteen states: Massachusetts, New York, New Jersey, Pennsylvania, Delaware, North Carolina, Missouri, Texas, Colorado, Washington, Oregon, California and Michigan, and it is a fair statement that effort is being made to establish medical plans under the medical profession's sponsorship in every state. One out of every nine persons in Michigan now has our surgical service, and one out of every five has hospital service.

* * *

The paragraph that follows was taken from an editorial that appeared in several papers and was entitled, "Expecting Too Much":

"Proponents of socialized medicine cannot expect the very same doctors who now vehemently protest the destruction of their freedom, to don the shackles of legislation such as the Wagner-Murray Bill and continue to serve with unimpaired efficiency. The doctors have a tradition of freedom behind them just as have the rest of us. They are used to living in and being part of a society of free men. In proposing to set them apart from this society, we have confronted them with an appalling prospect. Is it any wonder they rebel? Who wouldn't?"

* * *

Mr. Claud A. Williams, Chairman of the Texas Unemployment Compensation Commission, points out that the schedule of benefits under the Wagner-Murray-Dingell Bill exceeds the prevailing wage for farm labor all over the country and exceeds the earning capacity of fully 75 per cent of the veterans who will come back. He then asks, "What do you think will happen if a man can make more by being idle than he can by working? You can bet he will be idle. The bill puts a premium on being idle. . . ."

* * *

No organization can long remain on the defensive—it must sooner or later assume the offensive or lose its effects. The medical profession is no exception to the rule in this respect. Will American medicine meet the challenge? Are prepaid voluntary medical insurance plans, similar to those now being sponsored by various state and county medical societies, the antidote for socialized medicine?—*J. Missouri M. A.*, February, 1944.

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Woman's Auxiliary

A MESSAGE FROM THE HONORARY PRESIDENT

Upon request of our State President, Mrs. John Walch, I have consented to write a short message to all members of the Woman's Auxiliary to the Michigan State Medical Society.



MRS. GUY L. KIEFER

As your first President and later as your Honorary President, my interest and pride in the growth of this wonderful organization has been far beyond all expectations.

I congratulate all officers and each and every member for their support, loyalty and coöperation. By their efforts, they have made this one of the outstanding organizations of the State.

Much has been accomplished to further its aims. Its function and activities are far more important than ever before. As a Medical Auxiliary we should assume our share of the responsibility of safeguarding the ideals of American Medicine at all times—to aid in securing better medical legislation, to aid in the program on health education, to promote *Hygeia*. We have a personal obligation to our doctors' wives whose husbands are in the armed forces.

I have had the honor, quoted from our former President, Mrs. Butler, of being the "Mother" of this organization. Therefore, it gives me the privilege of giving a little advice. Life and work have changed for us. This is the critical point in our lives, and upon our handling of the situation hinges the question as to whether or not we shall continue to be a help and inspiration to our husbands, or in ways not always recognized even by him, become an added burden to his already heavy load. We must always remind ourselves that his work and responsibilities have not changed in essentials. It is of the greatest importance that we do not lose our sense of perspective and allow social and home interests to assume the position of prime importance and expect the world, including our husbands, to revolve about that cluster.

I appreciate that some young wives may criticize this attitude as "old-fashioned"; but while fashions in many unimportant things may change, the good old standard virtues remain the same.

Let us pledge ourselves anew to the great calling of being true helpmates to men engaged in the greatest profession in the world!

MRS. GUY L. KIEFER
Honorary President

COUNTY AND PERSONAL ACTIVITIES

100 PER CENT CLUB FOR 1944

Dickinson-Iron—E. B. Andersen, Secy.
Manistee—C. L. Grant, Secy.
Muskegon—Helen Barnard, Secy.
Newaygo—W. H. Barnum, Secy.
Northern Michigan—G. B. Saltonstall, Secy.
Ontonagon—W. F. Strong, Secy.

As of March 10, the above county medical societies have certified 1944 dues for every member of their respective societies, to be the first 100 per cent paid-up counties for this year.

O. O. Beck, M.D., Birmingham, addressed the Birmingham Exchange Club in February on "The Wagner-Murray-Dingell Bill."

* * *

Roster of 1944 Members.—The annual Membership Roster will be published in the May Number of THE JOURNAL. The list will contain the names of all active members in good standing, with dues paid by April 1, together with military members and emeritus members.

* * *

Oscar D. Stryker, M.D., Councilor of the 11th District, Michigan State Medical Society, spoke to the Mason County Medical Society Thursday, February 24, on the "Wagner-Murray-Dingell Bill."

* * *

"German Medicine," another excellent review of medcal work on a national basis, as seen through the eyes of H. E. Randall, M.D., Flint, was published in the *Genesee County Medical Society Bulletin* of February 8, 1944.

* * *

Professor C. E. A. Winslow has been appointed Editor of the *American Journal of Public Health.* The new editor took office with the April issue. Doctor Winslow is Professor of Public Health at Yale University, New Haven, Conn.

* * *

Paul H. Noth, M.D., and *John W. Hirshfeld, M.D.,* Detroit, are authors of an original article "Amebic Abscess of the Liver with Secondary Infection: Local

Applying Scientific Principles to a Good Idea

Scientific principles applied to the early automobile brought improvements resulting in a device that changed a way of life.

There has long been a general agreement as to the particular merit of tar preparations in the treatment of eczema (1) and chronic industrial dermatoses (2). Application of scientific principles to that good idea have brought forward a modern therapeutic agent that retains the values inherent in the base tars, yet avoids the objectionable features of early whole tar preparations. It is Tarbonis Cream.

It is a pleasant vanishing type cream that is clinically nonallergic and nonirritating, without odor. It is antipruritic, and has a background of excellent clinical acceptance.

It is especially recommended in the treatment of infantile eczema, seborrheic and eczematoid dermatitis, and the many forms of industrial dermatoses.



An unusual interest, resulting in many requests for literature and samples, may cause a slight delay, but these requests will be met in the order they're received.

(1) Diseases of Infancy and Childhood, L. Emmett Holt, Jr., M.D., and Rustin McIntosh, M.D., 11th Ed., p. 905, D. Appleton-Century Co., New York, 1940.

(2) Occupational Diseases, R. T. Johnson, M.D., p. 455, W. B. Sanders Company, Philadelphia, 1941.

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Treatment with Penicillin" which appeared in Clinical Notes, Suggestion, and New Instruments in JAMA of March 4.

* * *

C. L. Hess, M.D., of Bay City was appointed by Governor Kelly on February 18, 1944, to the State Advisory Council of Health, to take the place of R. C. Perkins, M.D., Bay City, resigned. Congratulations, Doctor Hess!

* * *

Nine months' internship.—The Michigan State Board of Registration in Medicine took action, effective January 1, 1944, to reduce temporarily as a war measure the twelve months' period of rotating internship training to nine months rotating internship training in a United States Hospital approved for internship.

* * *

Wilfrid Haughey, M.D., Editor of the MSMS JOURNAL, addressed the Battle Creek Torch Club and the Battle Creek Kiwanis Club during February on "Political Medicine." He also addressed the Southwestern District Dental Society at Battle Creek on March 23 on "Federal Bureaucracy."

* * *

R. L. Novy, M.D., Chairman of the Board of Trustees of the Wayne County Medical Society, was guest speaker at a community meeting on the Wagner-Murray-Dingell Bill held in Detroit on February 17. The meeting was sponsored by the National Lawyers' Guild, Detroit Chapter, the UAW-CIO, the American Association of Social Workers, Detroit Chapter, et al.

Doctor Novy was the only speaker on the program who presented the viewpoint of the practitioner of medicine on this proposal to socialize medicine.

* * *

The Cover shows an American soldier, wounded by shrapnel, being given blood plasma by one of his comrades. Note the compassion in the face of the native woman and the child's fear expressed by the clutched throat.

This photo, and that which appeared on the February MSMS JOURNAL cover, were obtained through the courtesy of the Bureau of Public Relations, War Department, Washington, D. C.

* * *

District Meeting.—V. M. Moore, M.D., Chairman of The Council, and Councilor of the Fifth District, arranged a District meeting at the Pantlind Hotel, Grand Rapids, on Tuesday, February 29. Physicians and their wives from Kent, Ottawa, Ionia-Montcalm and Barry Counties were present.

Floyd E. Armstrong, Professor of Economics and Finance, Massachusetts Institute of Technology, Cambridge, Massachusetts, spoke on "What Price Security." æ

One hundred and fourteen attended the meeting. Guests included Senators Earl W. Munshaw of Grand

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SURGERY—Two Weeks' Intensive Course in Surgical Technique starting April 3, 17, and every two weeks throughout the year. One-week Course in Colon and Rectal Surgery starts April 17 and June 5.

MEDICINE—Two Weeks' Intensive Course Internal Medicine starts June 19. Two Weeks' Course Gastro-Enterology starts June 5.

GYNECOLOGY—Two Weeks' Intensive Course starting June 12. One-week Personal Course Vaginal Approach to Pelvic Surgery starts April 17.

OBSTETRICS—Two Weeks' Intensive Course starts April 17 and June 26.

ANESTHESIA—Two Weeks' Course Regional, Intravenous and Caudal Anesthesia.

GASTROSCOPY—Personal Course starts April 3, June 19, and October 16.

OTOLARYNGOLOGY—Two Weeks' Intensive Course starts April 3 and October 2.

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Rapids and M. Harold Saur of Kent City and State Representatives Andrew Bolt, Thomas J. Whinery, Charles R. Feenstra of Grand Rapids, Maurice E. Post of Rockford and Bert J. Storey of Belding.

* * *

September 27-28-29.—These are the dates of the 1944 Postgraduate Conference on War Medicine of the Michigan State Medical Society, to be held in Grand Rapids. An outstanding program is being arranged by the Committee on Scientific Work, and announcements will appear in THE JOURNAL MSMS. The meetings will be held in the G. R. Civic Auditorium and in the Pantlind Hotel. For hotel reservations write the "Committee on Hotels, Michigan State Medical Society Postgraduate Conference on War Medicine, Pantlind Hotel, Grand Rapids.

* * *

The Michigan Pathological Society held its bimonthly meeting at Woman's Hospital, Detroit, on February 12. The meeting was held as a seminar on the subject "Diseases of the Thyroid Gland" and was conducted by D. C. Beaver, M.D., President. Microscopic slides of selected material were prepared and mailed to the members for their individual study two weeks prior to the meeting. Cases were presented by Drs. M. E. Maun, D. H. Kaump, F. W. Hartman, D. C. Beaver, J. A. Kasper, W. L. Brosius, J. G. Christopher, W. W. Zuelzer, and B. E. Stofer of Detroit; Dr. R. T. Lossman of Traverse City; Dr. R. J. Parsons of Ann Arbor; and Dr. S. E. Gould of Eloise. Dinner was served at the home of the Wayne County Medical Society.

* * *

EMIC Program.—The U. S. Children's Bureau has disapproved the original plan, developed by the Michigan State Medical Society, for payment of physicians through Michigan Medical Service for emergency maternal and infant care to servicemen's wives.

The 1943 Michigan State Medical Society House of Delegates expressed its opposition to direct payment of federal funds to doctors of medicine for care of private patients, and instructed the Michigan State Medical Society Council to negotiate for a more satisfactory arrangement of payment to physicians. It also requested Michigan State Medical Society members to sign *hospitalization* blanks, stating their willingness to care for their patients gratis pending negotiations.

While the Executive Committee of the Council is endeavoring to develop an acceptable plan, it is the sense of the Executive Committee that members of the Michigan State Medical Society may properly

(a) Sign the blanks to provide for hospital service, giving the professional care gratis; or
(b) Sign the blanks and accept the government fee for medical care; or
(c) Decline to participate in the program; *as they see fit*

* * *

"Who's Who in the Western Hemisphere."—Some physicians may receive invitations to send their biographies for "Who's Who in the Western Hemisphere." These doctors will be interested to know that the

Federal Trade Commission entered a complaint against the promoters of the book charging among other things:

"That their previous publications, such as 'Who's Who in Law,' and others of similar titles, do not possess the high standard of selectivity, accuracy and reference value found in the well-known 'Who's Who in America' issued since 1899 by another publisher, whose binding they imitate.

"That the promoters of 'Who's Who in the Western Hemisphere' have been gathering biographic material and soliciting subscriptions for it for over two years, having collected more than $25,000 in advance and obtained unpaid subscriptions for the work totaling an additional $25,000 though the volume is not off the press.

"That the promoters are neither financially nor professionally equipped to undertake the editorial duties or assume the financial risks involved in the publication of so ambitious a work as 'Who's Who in the Western Hemisphere,' and if sufficient copies are not sold or reserved prior to publication, the proposed book may never be issued, 'to the manifest and substantial loss and injury of the purchasing public.'"

* * *

Mustering-out Pay.—Machinery has been set in motion to make mustering-out payments to eligible veterans of current war who have been discharged or released from active duty under honorable conditions since December 1, 1941, reports Congressman Fred L. Crawford of Michigan. War Department estimates approximately 1,300,000 men have been discharged or released from active duty in all branches of service. Mustering-out pay law (Pub. Law 225, copy upon request) provides payment $100 to veterans with less than 60 days' active service; those with active service of 60 days or more and with no foreign service $200, payable in two monthly installments of $100; and veterans with service 60 days or more and who have foreign service will receive $300, payable in three equal monthly installments. Persons who become eligible for mustering-out pay subsequent to approval of law will receive payment from proper department without necessity of application. Veterans discharged or relieved from active duty prior to approval of the law must (1) Submit certificate of discharge or service. To assure return of certificate, write your present address on the certificate. (2) Submit informal type of certified application on which is stated his name and address; service number, serial number or file number; that he was not discharged or released to accept employment without service outside of the United States; that he is not now serving on active duty; that he has not and will not make any other application for the mustering-out payment; the State of which he was a resident at the time of induction or enlistment, and whether he has had foreign service. Commissioned officers of all

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services will be required to furnish evidence of length and termination of service to their respective departments. Navy and Coast Guard enlisted veterans will be required to file their applications with the Field Branch, Bureau of Supplies and Accounts, Cleveland, Ohio. Enlisted veterans of the Marine Corps will file their applications with the Commandant of the Marine Corps, Washington, D. C.

Michigan veterans of the Army, both discharged officers and enlisted personnel, will file their applications with the Finance Officer, U. S. Army, Jefferson and Livernois Avenues, Detroit, Michigan.

Among those not covered are veterans dishonorably discharged, men who were in certain student training programs, and officers of the Army and Marine Corps with a rating higher than captain or in Navy with rating higher than lieutenant.

* * *

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Every member of the Michigan State Medical Society has the golden opportunity of adding materially to his substantial interest in THE MSMS JOURNAL by clipping the coupons inserted in the advertisements. Some of our business friends gauge reader interest by the number of clipped coupons they receive from Doctors of Medicine.

* * *

Max Karl Newman, M.D., Detroit, presented the topic, Refrigeratioin Anesthesia, before the Bay County Medical Society, Bay City, on February 9, 1944.

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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

INDUSTRIAL AND ORTHOPEDIC SURGERY, The 1943 Year Book. Edited by Charles E. Painter, M.D., Orthopedic Surgeon to the Massachusetts Woman's Hospital and Beth Israel Hospital, Boston. Chicago: The Year Book Publishers, 1943, $3.00.

This volume is a review of all the available literature on this field of medical practice and an evaluation of what is good. Special caution is given about the tendency to be over optimistic regarding new procedures, especially in view of the war situation. There has been a dearth of medical literature from European and Asiatic sources. Abstracts are liberal, illustrations profuse, and very especial attention is given to Fractures and war injuries in general. This volume is no exception to the usefulness of these Year Books which have been appearing since 1900.

OFFICE TREATMENT OF THE NOSE, THROAT AND EAR. By Abraham R. Hollender, M.Sc., M.D., F.A.C.S. Associate Professor of Laryngology, Rhinology and Otology, University of Illinois College of Medicine; Otologist, Research and Educational Hospitals, Chicago, Illinois. Chicago: The Year Book Publishers, Inc., 1943. $5.00.

Office treatment of practically all the procedures capable of being followed in the office are given in this very handy book. The descriptions are good with reasons given and alternate treatments in many instances. There are sufficient and very good illustrations. Controversial subjects are avoided, the author giving his usual procedure. After each chapter he gives the references to authors and authorities so the student can look up the original and continue his studies. The book makes a very practical guide, and is well worth while.

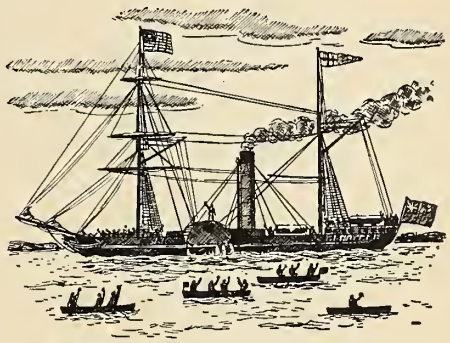
NASCENT ENDOCRINE THERAPY. By John Franklin Ritter, M.D., Caldwell, Idaho: The Caxton Printers, Ltd.

Dr. Ritter spent eighteen years in clinical research using what he calls nascent endocrine. He uses fresh secretions, and reports marvelous results in hypertension, hypotension, peptic ulcer, et cetera. Many case histories are reported. The technique is somewhat vague, but by careful search one finds how the interstitial testerone is made, by expressing the fluid from a fresh gland under sterile conditions. He also discusses endocrines from adrenal cortex, parathyroids, pituitary, and transplantation. This text throws all preconceived ideas to the winds, and at least claims challenging results. The book was written in 1940, and is just appearing for review. It is interesting as reading matter, and its scientific value must be judged by the interested practitioner with inclination to read and ponder.

THE PERMEABILITY OF NATURAL MEMBRANES. By Hugh Davson, D.Sc., Associate Professor of Physiology at Dalhousie University, Canada; Formerly Demonstrator of Biophysics, University College, London; and James Frederic Danielli, D.Sc., A.I.C., Beit Memorial Research Fellow and Fellow of St. John's College, Cambridge, England. With a Foreword by E. Newton Harvey, Professor of Physiology in Princeton University. Cambridge: At the University Press. New York: The Macmillan Company, 1943. $4.75.

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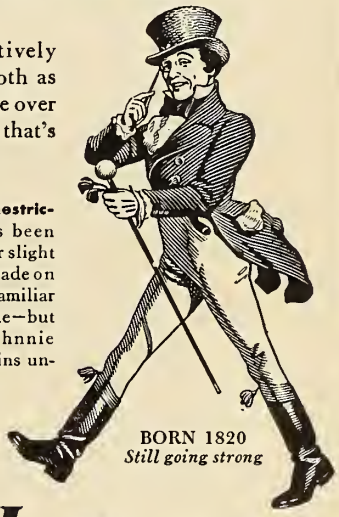


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to drugs and chemicals, and the body processes of living and dead tissues. This book brings together the existing knowledge of cell permeability. The researches of many are quoted, and the facts and formulæ are given in detail. It is a subject of great detail and elaborate experimentation. The student of cell metabolism will find much to stimulate him. The effects of narcotic substances on permeability are studied; also hemolysis, secretion, and the action of the kidney.

BACKACHE AND SCIATIC NEURITIS, Back Injuries, Deformities, Diseases, Disabilities, with notes on Pelvis, Neck, and Brachial Neuritis. By Philip Lewin, M.D., F.A.C.S., Associate Professor of Bone and Joint Surgery, Northwestern University Medical School; Attending Orthopaedic Surgeon, Cook County Hospital; Attending Orthopaedic Surgeon, Michael Reese Hospital; Professor of Orthopaedic Surgery, Cook County Graduate School of Medicine; Lieutenant Colonel, Medical Corps, U. S. Army. Illustrated with 235 figures. Philadelphia: Lea & Febiger, 1943. $10.00.

Backache has been an important symptom taxing the ingenuity of doctors from the earliest time. Exact knowledge is necessary to relieve it, and then results have not been too good. General practitioners and orthopaedic specialists should welcome this book by a recognized authority as giving them a new strength in tackling this age-old problem. Anatomy and muscle action, nerve distribution, and bony changes are most carefully studied, on the theory that too much knowledge of the subject is impossible. The illustrations are full, to the point, and adequate. Pages are given to the examination technique, to special tests, to treatment, to differentiation. The Kenny treatment of poliomyelitis is given in some detail, with its supporting theories. Disability laws, compensation aspects, evaluation of disability are all outlined. The book is in good style and touches a subject crying for help. It is a valuable addition to the doctor's library.

TRAUMATIC INJURIES OF FACIAL BONES. By John B. Erich, M.S., D.D.S., M.D., Consultant in Laryngology, Oral and Plastic Surgery at the Mayo Clinic, Assistant Professor of Plastic Surgery, The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota; Diplomate of the American Board of Plastic Surgery; and Louie T. Austin, D.D.S., F.A.C.D., Head of Section on Dental Surgery at the Mayo Clinic. Associate Professor of Dental Surgery, The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. In Collaboration with Bureau of Medicine and Surgery, U. S. Navy. 600 pages with 333 illustrations. Philadelphia and London: W. B. Saunders Company, 1944. Price $6.00.

This manual is devoted largely to maxillofacial injuries and their treatment. There are clear descriptions of the problem presented in the fractures and injuries, and then well illustrated plans of treatment. Especial emphasis is given throughout that the success of this work is in the functional result, as well as the cosmetic. The "bite" is of primary importance, and methods of assuring it are described and illustrated. Many kinds of fracture, simple, comminuted, multiple, are given, and each is analyzed and treated to the best advantage. Skeletal splints are used as well as interdental wiring, and prostheses. Bone grafts, cartilage implants, et cetera, are described, as well as the way to secure the implant material, and its preservation. The book is of flexible cover, handy size, and a work of art mechanically as well as technically.

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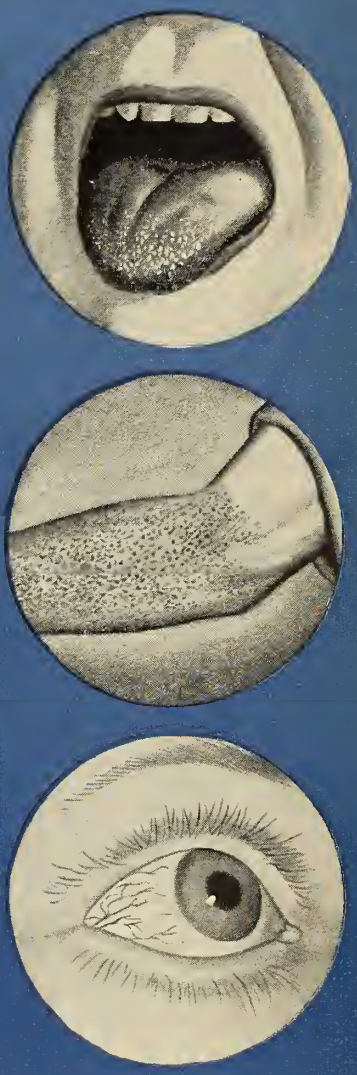
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New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division ,One Pershing Square, New York 17, N. Y.

MEDICAL INDUSTRIAL CONFERENCE

The Second Annual Postgraduate Industrial Medical and Surgical Conference, held in Detroit, April 6 was attended by 231 persons who registered high praise for the quality of the program and the smoothness of the physical arrangements in the Rackham Educational Memorial, Detroit.

C. R. Keyport, M.D., Grayling, President of the Michigan State Medical Society, presented the address of welcome. William J. Stapleton, Jr., M.D., Detroit, Associate Dean, Wayne University College of Medicine, presided at the morning session, and A. C. Furstenberg, M.D., Ann Arbor, Dean, University of Michigan Medical School, was Chairman at the afternoon meeting.

Charles-Francis Long, M.D., Philadelphia, Samuel Peck, Senior Surgeon, (R) USPHS, Bethesda, Maryland, Leonard E. Himler, M.D., Ann Arbor, Marion Jocz, M.D., Detroit, Melvin H. Pike, M.D., Midland, Carl A. Moyer, M. D., Ann Arbor, John W. Hirshfeld, M.D., Detroit, and Mohe H. Solworth, Louisville, Kentucky, were the guest speakers whose excellent presentations guaranteed the success of the Industrial Conference, sponsored by the Industrial Health Committee of the Michigan State Medical Society and by the Michigan Association of Industrial Physicians and Surgeons. Cooperating in the Conference were the Department of Postgraduate Medical Education, U. of M., and the Wayne University College of Medicine.

An exhibit on "Cutting Oil Dermatitis" was presented through the courtesy of the AMA Committee on Scientific Exhibit, Thomas G. Hull, Ph.D., Director.

The General Chairman of the day was Kenneth E. Markuson, M.D., Lansing, chairman of the MSMS Committee on Industrial Health.

Doctors of Medicine who attended the Conference included:

William E. Abbott, M.D., Grosse Pointe; F. T. Andrews, M.D., Lansing; A. L. Arnold, Jr., M.D., Owosso; Ira Avrin, M.D., Detroit.

Casco de Freitas Barcellos, M.D., Ann Arbor; John G. Barker, M.D., Ferndale; John C. Benson, M.D., Flint; C. C. Birkelo, M.D., Detroit; Kenneth E. Blair, M.D., Detroit; F. L. Blumenthal, M.D., Detroit; A. L. Brooks, M.D., Detroit; Philip H. Broudo, M.D., Detroit; James B. Brown, M.D., Detroit; D. J. Buckley, M.D., Detroit; Max Burnell, M.D., Flint; Paul C. Burnett, M.D., Grand Rapids; Howard A. Burrows, M.D., Dearborn; G. M. Byington, M.D., Detroit.

Corwin S. Clarke, M.D., Jackson; Emilie A. Clarke, M.D., Detroit; Raymond G. Colyer, M. D., Detroit; Robert P. Coseglia, M.D., Detroit; E. B. Cudney, M.D., Pontiac; J. E. Curlett, M.D., Roseville.

W. A. Dawson, M.D., Ypsilanti; William DeKleine, M.D., Lansing; Frederick E. Dodds, M.D., Flint; Max E. Dodds, M.D., Detroit; John D. Donovan, M.D., Detroit; Bruce H. Douglas, M.D., Detroit; Henry Duiker, M.D., Grand Rapids.

R. T. Ewing, M.D., Monroe.

L. Fernald Foster, M.D., Bay City; R. O. Fuerbringer, M.D., Detroit; A. C. Furstenberg, M.D., Ann Arbor.

H. H. Gay, M.D., Midland; C. W. Geiter, M.D., Detroit.

W. B. Harm, M.D., Detroit; C. K. Hasley, M.D., Detroit; Wilfrid Haughey, M.D., Battle Creek; Albert E. Heustis, M.D., Monroe; L. E. Himler, M.D., Ann Arbor; John W. Hirshfeld, M.D., Detroit; C. L. Hodge, M.D., Reading; J. Stewart Hudson, M.D., Grosse Pointe; T. H. Hunt, M.D., Detroit.

E. A. Irvin, M.D., Detroit.

Frank J. Jarzynka, M.D., Detroit; Marion W. Jocz, M.D., Detroit; N. D. Johnson, M.D., Detroit.

Herbert S. Karr, M.D., Detroit; R. A. Kennedy, M.D., Sarnia, Ont.; C. R. Keyport, M.D., Grayling; F. Bruce Kimball, M.D., Ypsilanti; David Kliger, M.D., Detroit; Lewis L. Kline, M.D., Highland Park; T. Kolvoord, M.D., Battle Creek; Wm. T. Krebs, M.D., Detroit; Earl G. Krieg, M.D., Detroit; Harley L. Krieger, M.D., Dearborn; Don F. Kudney, M.D., Jackson.

C. R. Lam, M.D., Detroit; John S. Lambie, M.D., Pontiac; M. B. Landers, Jr., M.D., Detroit; A. F. Lecklider, M.D., Detroit; Earl F. Lutz, M.D., Detroit.

Frank T. McCormick, M.D., Detroit; L. N. McNair, M.D., Albion.

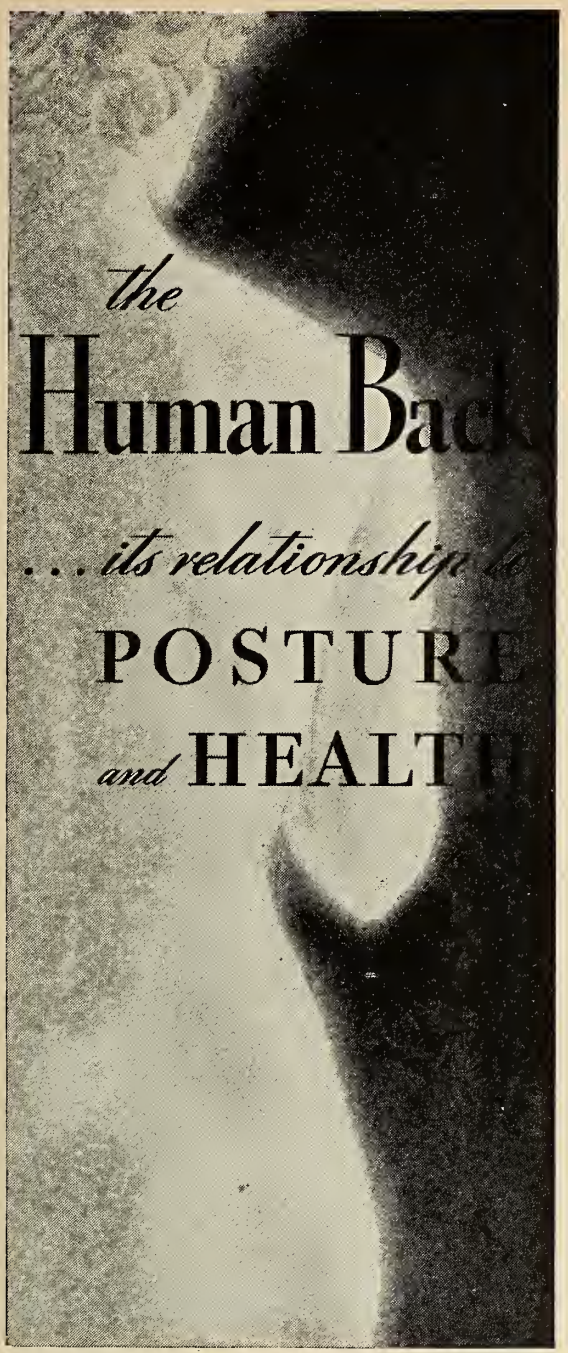
K. E. Markuson, M.D., Lansing; Wayne O. Martin, M.D., Lansing; Stuart F. Meek, M.D., Detroit; Esli T. Morden, M.D., Adrian; Victor C. Myers, M.D., Lansing.

Charles A. Neafie, M. D., Pontiac.

Charles H. O'Donnell, M.D., Detroit; Howard J. Olk, M.D., Detroit; L. Orecklin, M.D., Detroit.

Melvin H. Pike, M.D., Midland; S. M. Poindexter, M.D., Boise, Idaho; Sr. Surg. Samuel

(Continued on Page 362)



May we send you this helpful new booklet FREE *for presentation to your patients?*

Last year the Samuel Higby Camp Institute for Better Posture, in collaboration with eminent authorities, prepared a little booklet "Blue Prints for Body Balance" which has been supplied to thousands of physicians, free, at their request. Now we have prepared a new companion booklet which is just off the press.

This additional sixteen-page booklet, "The Human Back . . . Its Relationship to Posture and Health," tells its story in simple, non-technical language, and is attractively illustrated. It is educational, non-commercial, informative . . . an ethical booklet for physicians to give their patients. We believe it will inspire its readers to a better appreciation of the importance of good posture and professional medical counsel.

We shall be glad to send you as many copies as you wish, free. The booklet measures 3½ by 6½ inches, and is attractively printed in color. Just use the coupon below, or write on your professional letterhead to the

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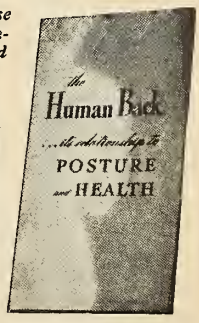
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"WHAT THE PEOPLE THINK OF MEDICINE"

1. Only 16 per cent of the American people approve of a 6 per cent payroll deduction from wages for the Federal Government to provide medical care and hospitalization.

2. But—63 per cent of the American people ask for an easier method of paying the costs of unusual or prolonged illness and of hospitalization, such as is provided by the voluntary non-profit plans (Michigan Hospital Service and Michigan Medical Service) which have been serving the people of Michigan for five years.

A national survey, made by the Opinion Research Corporation, Inc., of Princeton, New Jersey, for the National Physicians Committee, has just been announced. The survey covers a three months' period from November 1, 1943, to February 15, 1944. Answers to questions were secured from all types of laymen in every age group, race, size of community, and occupation.

The summary of conclusions indicates a crystal-clear case whose implications cannot be ignored.

People Want Voluntary Pre-Pay Plans

The American people want none of the National Government's meddling in the vital field of medical service. They want personalized medical care.

The American people know about and are demanding a plan or plans for the pre-payment of medical care costs.

This demand must be met. It is an economic problem, not exclusively a medical responsibility. The Professions, Insurance Companies, American Labor, all of Business and all of Industry are equally involved.

The Challenge

The private enterprise system will be preserved by meeting the needs of the people.

This is the task of every individual—every group—every agency—every business and every industry interested in preserving for the United States the private enterprise system.

This Survey of Opinion on Medical Care conclusively demonstrated that the people do not understand these issues; when they do understand, an overwhelming majority are opposed to the governmental proposals; but, they sense the need for an extension of facilities designed to aid in meeting the costs of unusual or prolonged illness.

When asked the question:

"Have you ever heard of a plan to increase social security taxes and have the Federal Government use the money for a Medical and Hospital Insurance Program?" "Would you approve or disapprove of such a plan?" only 21 per cent of all the people had heard of the proposals; when explained, only 32 per cent of all the people in the United States expressed approval of the Federal Government providing medical care.

And when asked—

"Would you still approve if this meant increasing Social Security taxes to 6 per cent?" one half of this number deserted, leaving only 16 per cent of the people who were in favor of such far-reaching and actually revolutionary measures.

These enlightening statements of opinion represent a nationwide, predominant majority repudiation of any attempt to Sovietize American medical care.

The Need

When asked—

"Do you think anything might be done to make it easier for the people to pay doctor or hospital bills?" sixty-three per cent of all the people voiced the opinion that methods could be devised for easier payments of medical care costs.

This opinion cannot—dare not—be ignored.

When asked the question—

"Do you think that an easier method of payment is needed to meet 'ordinary' doctor bills, or just to take care of 'serious emergency' illnesses?" only five per cent think that *ordinary* doctor bills require an easy method of payment.

Fifty-four per cent of all the people hold the opinion that some plan of easy payment must be provided for the payment of costs for unusual and general illness.

Answers to another question brought out that 22 per cent of all of the people employed by American industry worked for firms which provide a plan for paying the costs of serious illness. But—74 per cent of all workers in all industry are not included in group pre-payment plans!

The people know about plans or methods for insurance against the hazards of emergency illness. They desire to participate in such plans. Again, this is an economic—not

(Continued on Page 362)

Announcing... the establishment of the

BARLOW-MANEY LABORATORIES

PHARMACEUTICAL CHEMISTS

Administration and company policy will be directed by

MR. ARTHUR A. BARLOW
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Product development and laboratory direction will be under the supervision of

MR. PAUL V. MANEY
Executive Vice-President

The acknowledged ability of Mr. Barlow in the financial and management fields, plus Mr. Maney's high professional standing assure a policy and product standard in keeping with the best traditions of the ethical pharmaceutical industry.

Barlow-Maney
LABORATORIES
Cedar Rapids Iowa

(Continued from Page 360)

exclusively a medical—problem. Its solution is the joint responsibility of the medical profession, other professional groups, labor, American industry, and insurance companies.

Answers to the following two questions will be of interest:

"Have you ever heard of a plan to increase social security taxes and have the federal government use the money for a medical and hospital insurance program? Would you approve or disapprove of such a plan?"

	Have Heard	Haven't Heard	Approve Plan	Disapprove Plan	No Opinion
TOTAL	21%	79	32%	42	26
Upper income group	37%	63	29%	52	19
Middle income group	24%	76	31%	48	21
Lower income group	13%	87	33%	35	32
East	22%	78	35%	46	19
Midwest	23%	77	30%	44	26
South	17%	83	30%	35	35
Far West	25%	75	37%	44	19
Farm residents	16%	84	26%	35	39
Under 2500	22%	78	32%	45	23
2500-24,999	21%	79	32%	43	25
25,000-499,999	24%	76	31%	47	22
500,000 & over	25%	75	42%	43	15
3 or less in family	21%	79	32%	45	23
4 or more	21%	79	33%	39	28
Union members	21%	79	39%	39	22
Non-members	21%	79	31%	43	26
Men	25%	75	33%	46	21
Women	17%	83	31%	40	29

"Do you think it would be good or bad for the county if schools, churches, labor unions, medical profession were controlled by the national government?"

	Schools			Churches			Labor Unions			Medical Profession		
	Good	Bad	No Op.	Good	Bad	No Op.	Good	Bad	No Op.	Good	Bad	No Op.
Total	23%	63	14	4%	90	6	46%	40	14	24%	61	15
Upper Income groups	17%	75	8	2%	95	3	44%	49	7	18%	75	7
Middle Income group	21%	69	10	3%	92	5	45%	44	11	22%	66	12
Lower Income group	27%	54	19	7%	85	8	47%	34	19	29%	51	20
East	23%	63	14	5%	89	6	42%	45	13	22%	64	14
Midwest	20%	69	11	4%	92	4	46%	42	12	22%	66	12
South	26%	57	17	6%	86	8	53%	29	18	28%	53	19
Far West	22%	67	11	3%	92	5	37%	51	12	28%	58	14

It is interesting to note that 46 per cent of all persons favored federal control of labor unions and 40 per cent were against such control, while 24 per cent favored federal control of the medical profession and 61 per cent were against such regimentation. Also, that 4 per cent favored federal control of churches—which would indicate that this 4 per cent desires to sovietize everything.

People Against Compulsion

This Survey of Opinion on Medical Care, the most comprehensive of its kind ever made in the United States, conclusively demonstrates that the American People do not wish to pay more taxes and to be dependent upon the "State" for medical care. They desire to participate in *voluntary* plans, similar to the Michigan programs developed by the medical and hospital professions working in close coöperation with other professional groups, with labor, and with industry.

HEALTH INSURANCE FOR CANADA

A plan of State Health Insurance is being proposed for Canada. They have determined what the cost of health services in Canada were in 1938, the last prewar year, and have divided that figure by the number of persons who will benefit, and find that complete health insurance will cost $26.00 a year per person. Schemes are being planned to raise by taxation or withholding plans sufficient money to raise that amount. Those who earn as much as $780.00 per year will pay 3 per cent for each adult. The employer will make up the difference for the employe, but the difference for the dependents will be made up by the state. The bill covers administration, the use of dentists, chiropractors, osteopaths, chiropodists, etc., with a provision that these cults must observe a rigid code of ethics which forbids any trespassing on the fields occupied by practitioners of medicine or surgery. It is pointed out that under this law all eligible persons are entitled to full health service including hospital and doctor, but how can this be done in districts, and there are some, in which there are no such services available. That same question could be raised against the Wagner-Murray-Dingell bill.

MEDICAL INDUSTRIAL CONFERENCE

(Continued from Page 358)

M. Peck, USPHS, Bethesda, Md.; C. M. Peterson, M.D., Chicago; Felix Pinkus, M.D., Monroe; Hermann Pinkus, M.D., Monroe; Frank A. Poole, M.D., Saginaw.

S. H. Randolph, M.D., Detroit; P. B. Rastello, M.D., Detroit; E. H. Reed, M.D., Detroit; Gerald N. Rein, M.D., Benton Harbor; Ralph W. Ridge, M.D., Wyandotte.

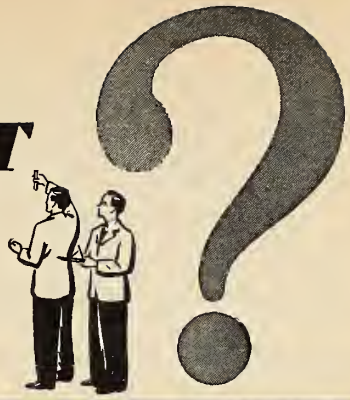
Clement Scott, M.D., Detroit; C. D. Selby, M.D., Detroit; Leon E. Sevey, M.D., Grand Rapids; Clara Sargent Shepherd, M.D., Lansing; Loren W. Shaffer, M.D., Detroit; Delbert Siler, M.D., Bay City; B. R. Springborn, M.D., Detroit; William J. Stapleton, Jr., M.D., Detroit; Don F. Strohschein, M.D., Detroit.

E. V. Thiehoff, M.D., Lansing; J. Oscar Thomson, M.D., Grand Blanc.

Joseph E. Waddington, M.D., Detroit; Martha Wells, M.D., Detroit; Earl C. Weston, M.D., Detroit; Charles J. Westover, M.D., Plymouth; A. H. Whittaker, M.D., Detroit; John Williamson, M.D., Detroit; Sherwood B. Winslow, M.D., Battle Creek; J. J. Worzniak, M.D., Hamtramck.

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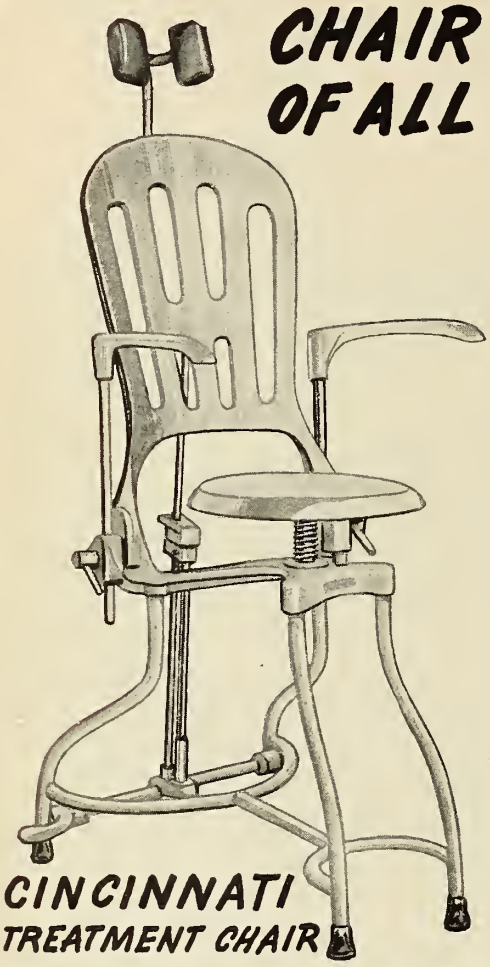
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WAR BULLETINS

1,194 U. S. SOLDIERS ARE AMPUTATION CASES

Washington—(AP) March 25—The army divulged through Rep. Edith Norse Rogers (R., Mass.) that 1,194 American soldiers have had arms or legs amputated thus far in the war.

The information was given to the house by Mrs. Rogers to squelch "ugly rumors" about fantastic numbers of amputations and "basket" cases—those with both legs and both arms off—which she said were becoming current.

Brig. Gen. Fred W. Rankin, chief consultant in surgery, wrote a letter to the congresswoman, which she placed in the Congressional Record, concerning the rumors and giving the latest figures on the amputations.

The 1,194 patients who had major amputations included sixty-eight who lost two limbs. There was "not a single triple amputation nor was there a single quadruple, or so-called 'basket type' of case," the general said.

SOLDIER DEATH RATE UNDER 1917-18

Whereas 156 American soldiers in 10,000 died annually from disease in the first World War, only six per 10,000 died per year from disease in this war, Brig. Gen. Hugh J. Morgan, chief consultant in medicine, office of the army surgeon general, told a war session of the American College of Physicians in the Palmer House, Chicago.

"This war will be won by effectives," he said. "Effectives in an army sense are men kept healthy by preventive medicine and, when this fails, restored to health by internal medicine. Our record in dealing with non-effectiveness thus far has been superb."

In the first World War, the death rate from pneumonia was 28 per cent. Now it is .7 of 1 per cent. Tuberculosis killed 17.3 per cent of those whom it attacked in the earlier conflict. Now all but 1.8 per cent are saved. The death rate from battle casualties has been 3.3 per cent now as against 8.1 in the other war.

Surgeons save ninety-seven out of 100 wounded men admitted to army hospitals.

The value of the airplane as a means of evacuating wounded and sick men to base hospitals quickly, safely and comfortably was stressed by Maj. Gen. David N. W. Grant, air surgeon of the army air forces, in a paper read for him, in his absence, by Col. W. Paul Holbrook, a member of his staff.

"Air evacuation has taken its place with the sulfa drugs and blood plasma as one of the three great life savers of modern military medicine," Gen. Grant's paper read.

There were statistics showing the growth of air evacuation since its beginning early in the war. A total of 173,000 casualties were moved in this manner in 1943. Deaths in transit are extremely few.

Say you saw it in the Journal of the Michigan State Medical Society



THE "SMOOTHAGE" REGIMEN
with
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1. A rounded teaspoonful of Metamucil stirred into a glass of water, milk or fruit juice, three times a day.
2. Follow each dose with a large glass of water.

EMPLOYED in this manner, Metamucil provides the soft, mucilaginous bulk which is desirable for natural elimination. No roughage, no oils, no chemical irritants.

Metamucil—providing "smoothage," a modern concept for treatment of constipation—is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

Metamucil is the highly purified, non-irritating extract of the seed of the psyllium, Plantago ovata (50%), combined with anhydrous dextrose (50%). Mixes readily with liquids, is palatable, easy to take.

Supplied in 1-lb., 8-oz. and 4-oz. containers.

Metamucil is the registered trademark of G. D. Searle & Co.

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SEARLE
RESEARCH IN THE SERVICE OF MEDICINE

POLITICAL MEDICINE

DIOCLETIAN AND HIS PLANNED ECONOMY

In 301 A. D. the Roman people suffered from an unprecedented depression, and Diocletian took over affairs with a planned economy for the Roman Empire. The Senate lost political identity, and republican institutions disappeared. Diocletian believed that social security could be secured and the economic affairs of the Empire permanently stabilized through federal bureaus and commissions. With his absolute authority he fixed by decree most of the intricate processes of social and economic life. Prices of some 800 articles were fixed with ceilings placed in plain sight. Wages for services from common laborer to dancing teacher and professional advocate were determined, and the bureaucrats regimented everything from the number of acres a farmer could plant to the number of hours labor could be employed. Rents were fixed and rationing enforced. *About the only group Diocletian's edict did not regulate was physicians.*

Even with the repealing of the law of supply and demand, and the complete regulation of the economic and social life of the people, Rome flourished for a time and both its population and the multiplicity of its bureaus and coördinators increased. Then something happened. The verdict of history is that Diocletian made the fatal mistake of failing to recognize one significant fact: that neither he nor his legions could control human nature. His scheme collapsed because black markets flourished and production stopped. Manufacturing was neglected, farmers quit tilling their soil, moved to cities, competition disappeared, and society became decadent. Individual freedom was destroyed; collective initiative perished and enthusiasm was extinguished. Diocletian's scheme took all incentive out of work.

It took 150 years to accomplish the complete disintegration of the Roman empire and a thousand years for Europe to recover. In the planned economy of THIS AGE medicine is included. Will the results be as far reaching and will it take as long to accomplish either end.

SOCIALIZED MEDICINE

Dear Doctor W.:

I have been reading again the article by Walsh on "Socialized Medicine." It covers a lot of ground and is completely convincing. However, there are many other things against state medicine. One of the principal arguments is the tendency it would have to do away with the personal responsibility of the physician.

The State, as such, has no sympathy and no soul and no feeling. Its individual representative has no responsibility beyond his obligation to the state. There could not be those delicate ties that subsist between the family physician and the family. A good, responsible, independent doctor is the family's best friend. They go to him, as you know, for advice in many more matters than medicine. This would be entirely done away with if state medicine were inaugurated. There is a great deal more to the question than mere economics, even though that is mighty important.

Your friend,

CHASE S. OSBORN

Bull Calhoun C.M.S., (Sept.) 1936

*The facts about Diocletian were in an address by Clayton Rand before the Rotary Club of Gulfport, Miss.

STATE MEDICINE

In West Virginia the state relief administrator himself wrote a county relief supervisor:

"I hand you herewith a list of doctors in Ohio County. Kindly separate the Democrats and the Republicans, and list them in the order of priority so we may notify our safety foremen and compensation men as to who is eligible to participate in case of injury."—from an editorial, CHICAGO DAILY NEWS.

What would happen if the whole practice of medicine were regimented under political dictation?—*Bull. Calhoun C.M.S.* (Oct.) 1936.

DELETE THE CONTROVERSIAL SECTIONS

Discussion goes on apace about the social security proposals of the Wagner-Murray Bill. Among public welfare administrators, there is increasing concern that the organized opposition to the controversial issues of compulsory health insurance and federalization of unemployment compensation may delay or kill consideration of the comparatively noncontroversial provisions for a unified public assistance program and broader OASI coverage. In the past few weeks the specific provisions of the Wagner-Murray Bill under Title XII "Unified Assistance Program" have been discussed in detail at a meeting of the Association's War Services Committee, the annual meeting of the Board of Directors of the APWA and at informal gatherings of state welfare administrators who were attending the Children's Bureau meetings in Washington. All these discussions led to a proposal to explore the possibility of a separate bill to incorporate the comparatively noncontroversial provisions of the Wagner Bill included under the assistance title. The area of agreement on amendments to the assistance titles of the Social Security Act is below indicated with a second possibility shown in case the first was found unattainable.—American Public Welfare Association.



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Restores Normal Intestinal Motility
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DO YOU WANT YOUR SOCIAL SECURITY TAX DOUBLED?

That is what the Wagner-Dingell Social Security Bills (S-1161 and HR 2861) propose—an increase to 12 per cent in employer-employe payroll "contributions," on top of the most staggering tax load of all time. On wages, or earned income, up to $3,000, this proposed legislation contemplates a—

6 per cent tax for employers
6 per cent deduction for employes
7 per cent tax for the "self employed"
3½ per cent tax (under certain conditions) for Federal, State and Municipal Employes
Note: The bureaucrats pay only one-half what the self-employed contribute!

United States Senators and Congressmen from Michigan

SENATORS
(U. S. Senate, Washington, D. C.)

Arthur H. Vandenberg (Grand Rapids)
Homer P. Ferguson (Detroit)

CONGRESSMEN
(House of Representatives, Washington, D. C.)

1st District	George Sadowski	(Detroit)
2nd District	Earl C. Michener	(Adrian)
3rd District	Paul W. Shafer	(Battle Creek)
4th District	Clare E. Hoffmann	(Allegan)
5th District	B. J. Jonkman	(Grand Rapids)
6th District	Wm. M. Blackney	(Flint)
7th District	Jesse P. Wolcott	(Pt. Huron)
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9th District	Albert J. Engel	(Muskegon)
10th District	Roy O. Woodruff	(Bay City)
11th District	Fred Bradley	(Rogers City)
12th District	John B. Bennett	(Ontonagon)
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3. This proposed egislation would create a **bureaucracy** with vast **political influence,** threatening the fundamentals of democracy.

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5. This is no time to railroad through an uneconomic and revolutionary social experiment—directly opposed to the principles for which we are fighting—under cover of the war emergency.

IF NOT . . . DO THIS TODAY!

Write your Senators and Congressmen and voice your objections.

Table of Contents

Small Unrecognized Strokes.
Walter C. Alvarez, M.D. 389

A Small Diphtheria Outbreak in Sturgis.
Frederick A. Musacchio, M.D. 392

Methods of Personality Study in Relation to Medical Practice.
J. C. Whitehorn, M.D. 395

Palindromic Rheumatism (Hench's Disease).
J. Gregory Grego, M.D., and *Henry N. Harkins, M.D.* 401

Wartime Obstetrics.
E. D. Plass, M.D. 402

An Interlocking Finger Bandage Which Needs No Anchor.
H. H. Pool, M.D. 406

President's Page:
Keep the Home Fires Burning 407

Editorial:
We Need a Book 408
The Michigan Health Council 409
Wagner-Murray-Dingell Bill 409

Roster—Michigan State Medical Society 410

You and Your Business 428

Michigan's Department of Health 430

Woman's Auxiliary 432

In Memoriam 434

County and Personal Activities 437

The Doctor's Library 442

Medical Industrial Conference 358

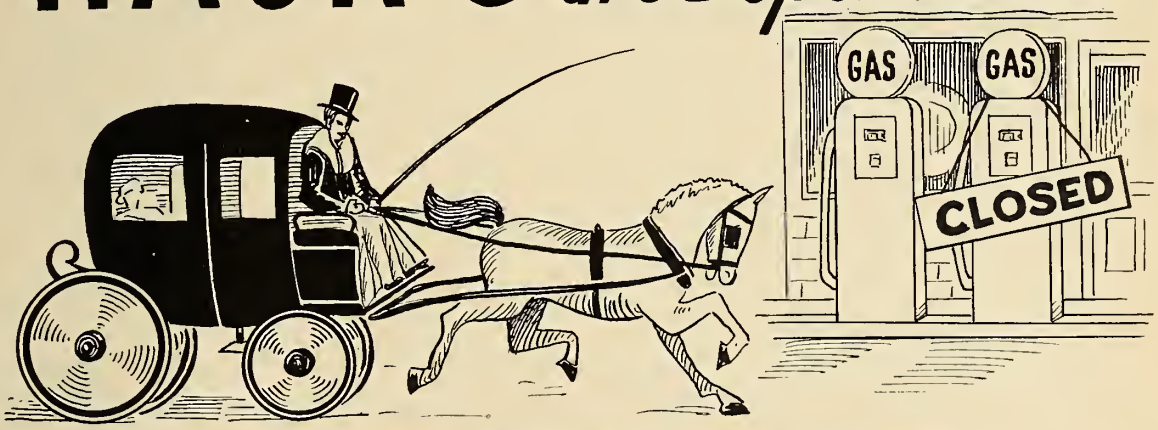
What the People Think of Medicine 360

War Bulletins 364

Political Medicine 366

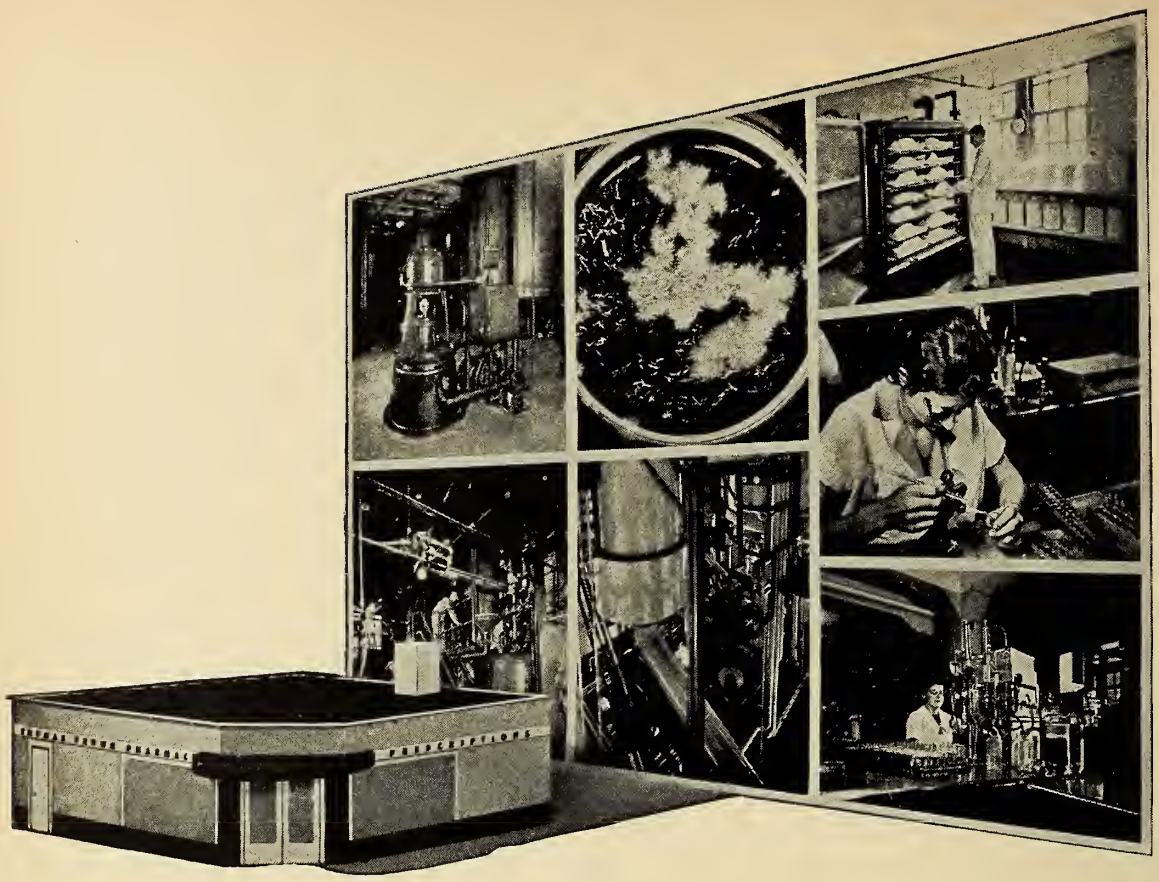
Do You Want Your Social Security Tax Doubled? 368

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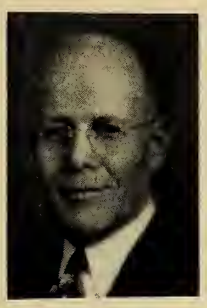
Issued Monthly Under the Direction of the Council

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Small Unrecognized Strokes

A Common Cause of Illness in Older Persons

By Walter C. Alvarez, M.D.
Rochester, Minnesota



Professor of Medicine, University of Minnesota (Mayo Foundation). Editor of Gastroenterology.

The gastro-enterologist sees many persons past forty complaining of abdominal pain or distress, indigestion, perhaps a sudden large loss in weight, perhaps an inability to work, perhaps aches and pains all over. The diagnosis must be made from the history, which is that the distress came suddenly one day, perhaps with a fall, or a spell of dizziness, vomiting or mental confusion. Most significant in many cases is the associated disability which is out of proportion to the other symptoms. There may be character changes, loss of memory, loss of interests, and perhaps loss of all joy in life.

■ Why should a gastro-enterologist be talking about little strokes? Because several times a month he sees patients with supposed indigestion or liver trouble who really have had a tiny stroke. Some little vessel in the brain has become plugged with a clot, and this has caused a small globule of brain to be destroyed. With this there may have been a dizzy spell, perhaps with nausea or vomiting or some mental confusion, or perhaps a sort of nervous storm running down the vagus nerves into the abdomen, there to produce a distressing feeling.

Read at the third War Conference on War Medicine, the Seventy-eighth Annual Session of the Michigan State Medical Society, at Detroit, September 24, 1943.

Some of you will say, "But surely not every dizzy spell is due to a little stroke. Aren't most of them due to harmless changes in the ear or liver or colon?" Yes, many must be due to fairly harmless changes somewhere because they seem to leave no residue of injury to the body, and others may be due to a temporary spasm in a little blood vessel, but especially when severe vertigo is associated with some mental confusion and is followed by a nervous breakdown with decided changes in character, one can be almost certain that a small part of the brain has been destroyed by the thrombosis of a blood vessel.

I remember well a woman who, during the course of ten years, had many dizzy spells with nausea and vomiting. Some left her nervously shaken and unable to leave her bed for a week or longer. With each one she aged a bit; she lost weight, and she lost some of her joy in life. Only one of these little strokes temporarily affected an arm and leg, and even the one that finally killed her failed to weaken a single muscle. What I wish to emphasize is that at necropsy sections of her brain were found to be speckled with areas of softening and the scars resulting from the healing of such areas. There were plenty there; enough to account for all of her dizzy spells, and all but one of the infarcts was in a so-called silent area. I am sure that any good physician seeing her in one of her attacks of vomiting would have thought only to ask her what she had eaten a few hours before, and he would have been satisfied to prescribe a laxative and a few days of light diet. Only the members of the family who watched the results of each successive injury to her brain could guess what was actually happening.

Big strokes are common enough and surely lit-

tle ones must be even commoner. As Janeway and Osler pointed out years ago, a large percentage of people with high blood pressure die a brain death. Little by little, during the course of ten years or more, the brain is destroyed, and as it goes the poor victim ages and becomes more slowed up. The same thing happens to an even greater number of aging women who haven't hypertension.

The sad fact is that we physicians were never trained to recognize the little strokes when they come. Even when someone tells us that a patient has had a stroke we, as a profession, are exceedingly reluctant to accept the diagnosis. We all depend so much on laboratory tests that we seldom think to take the type of history which alone will give us the diagnosis of a small stroke. Often this history can be obtained only from the family or from business associates. Only they will tell of the character changes which are so important and so revealing.

To illustrate: A little old lady complained of epigastric pain which came the minute she put food into her stomach. All roentgenologic and laboratory tests had failed to show anything wrong and every conceivable type of treatment had failed to help. Her physicians did not even suspect what was wrong because the assistant who had taken the history had not gotten any part of the all-important story. This was that the trouble had come at a certain minute of a certain day. Actually, at 7:30 in the morning of a certain Tuesday, while getting breakfast, she suddenly sat down and for the next two hours in a dazed sort of way kept asking over and over again, what had happened. When asked if the woman had suffered any change in character the husband said that in a moment she had been changed from an able, wide-awake, cheerful woman into a sad, apathetic and forgetful person who had to be looked after like a child. Interestingly, although to my way of thinking there was no question about her having had a stroke, her attending physicians thought this diagnosis too preposterous even to be entertained. There had been nothing in their medical training to prepare them for the idea.

Points in the Diagnosis

To me it seems almost pathognomonic of a stroke when the fact can be established that an elderly person who formerly enjoyed good health, suddenly, at a certain minute of a certain day, fell seriously ill. Perhaps he fell down and was a bit confused for awhile afterward. Perhaps he went to the hospital for a few weeks and was thought to have "intestinal flu" or some other vague disease. As has already been shown, he may have had a dizzy spell, and for a time afterward was fearful of walking without support. Sometimes the history is not so clear, but even then it may be established that the illness began one morning when the patient woke feeling upset and miserable or with a bad headache. In such cases what probably happened was that a blood vessel plugged up during the night when the blood pressure was at its lowest point. Many little strokes produce so little shock that they cannot be recognized even when they come during the waking hours.

The most pathognomonic point, which must never be glossed over, is that with a dizzy spell or a fall or an attack of vomiting, there came a decided change in character or temperament, perhaps with an increased irritability, a loss of efficiency, a loss of memory and interests, an inability to work, or an inability to feel any joy in life. It must be remembered that no disease of the abdominal organs, no matter how severe, can, in a moment, cause such a profound change in the character and health of the victim.

Often, when I have been unable to be sure from its nature that a particular episode represented a little stroke, I have felt fairly certain of it after I learned that the illness was preceded or followed by a series of other episodes which were obviously strokes with injuries to a motor or sensory nerve tract.

One other feature which, I believe, is almost pathognomonic of a small stroke is the discovery that a blood pressure which formerly was high, dropped to normal after the episode and perhaps then remained low.

Symptoms that Arouse Suspicion

Vertigo.—As already noted, vertigo, especially when associated with nausea, vomiting, mental confusion and subsequent prostration, is sometimes due to thrombosis of a small artery in the brain.

Paresthesia or Pain in Abdomen or Thorax.—Some small strokes cause a sudden distress or even a severe pain in abdomen or thorax, and again, the diagnosis must be made from such facts as, (1) that the patient suffered mental con-

fusion and perhaps later a nervous breakdown, (2) that at no time was there any sign of organic disease in thorax or abdomen, and perhaps, (3) that the patient did not recover in the slightest but drifted on with a step-like progression into arteriosclerotic dementia.

Slight Bulbar Palsy.—Occasionally, if the physician will inquire carefully he will get the story that following a dizzy spell or a fall or a curious attack of abdominal distress, there was some difficulty in swallowing, with ropy saliva, and a tendency for food to enter the larynx and there produce violent coughing.

Sudden Unexplained Loss of Weight.—Occasionally the main symptom complained of by a patient who has had a small stroke is a sudden and permanent loss of from 20 to 60 pounds. All examinations will fail to show any cause for this, and with the passage of years it will become apparent that the cause could not have been cancer, hyperthyroidism, or any other such well-known disease. It would seem to have been due to injury to one of the little regulators in the hypothalamus which normally holds the body weight at a constant level.

A Bad-tasting or Burning Mouth.—An occasional woman of fifty or so will complain of a bitter or metallic or acid taste, or a burning in her mouth for which no local cause can be found. For years I have been coming more and more to suspect that these persons have suffered a slight injury to the brain or to some nerve tract or nerve supplying the mouth or tongue. These people are at the right age for a stroke, and their distress is typically incurable. I have never seen one of them helped by treatment of any kind.

Pain in the Face or Head.—In older persons some of the poorly understood and highly intractable pains in the face or head may well be due to a slight stroke. Again, the age is right; there may be strokes before and after the pain comes, and no treatment gives any relief.

Diarrhea.—In older persons sudden short attacks of diarrhea may be due to a little stroke which either disturbs the nerves to the bowel or from time to time causes the patient to go into a panic of fear that he is going insane or going to have a stroke. As everyone knows, fear can easily produce diarrhea.

Shuffling of the Feet.—When an aging man suddenly begins to shuffle his feet a bit or to take small steps or to walk unsteadily one must think of arteriosclerotic changes in the brain and spinal cord.

Insomnia.—Insomnia coming suddenly and unaccountably in an older person who has previously slept well suggests that there has been a slight stroke.

Over-emotionalism.—A woman past middle age may suddenly find herself crying at the slightest excuse or for no reason at all. She will maintain that she is not melancholy and has no reason to be. Again, there probably has been an arteriosclerotic injury to some part of the thalamic region of the brain.

Parkinson's Syndrome.—Parkinson's syndrome may appear after one or a series of sudden episodes which suggested small strokes.

Numbness.—Many persons past middle age complain of numbness in an arm and hand which causes them to fear that they had a stroke or are going to have one, but my impression is that they are not more subject to strokes than are other persons.

Prognosis

One good reason for making the diagnosis of a stroke is that so often, when there has been much injury to a certain part of the brain, the patient never improves in the slightest and remains a most unhappy invalid. In such cases the wise and kindly physician will not want to keep putting the patient through one long and futile examination after another; he will want to be saved the embarrassment of having promised a cure, and often he will want to warn the family that their wage-earner will never work again. He will want also to explain the situation to the family so they will understand and be more kindly, and less inclined to scold the patient and exhort him or her to snap out of it. When much of the brain is destroyed the patient cannot possibly "snap out of it."

Naturally, when the injury to the brain is a small one, and new ones do not come for a long

time the patient can recover from an episode and can do very well. As I was writing this paper I saw two well-groomed wide-awake and able businessmen aged about fifty-five who, at the age of forty years had each had a stroke. One had a typical big one from which he recovered well, and only recently has he begun to have little ones. The other man had a little stroke which dropped his high blood pressure to normal, and he does not seem yet to have had another in spite of tremendous overwork.

Hence, when a patient asks anxiously if the fact that he has had a little stroke means that he'll soon have another we can answer, "Not necessarily, and it is no use worrying about it."

Treatment

So far as I know there is no logical treatment except perhaps taking life more easy and avoiding excesses, especially of temper. There are drugs such as iodides which one can give, but it is impossible to determine if they do any good. In some cases soporifics are needed.

MSMS

A Small Diphtheria Outbreak in Sturgis

By Frederick A. Musacchio, M.D.
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In spite of long-range diphtheria immunization programs now being conducted throughout the country, this preventable disease remains with us. Its eradication is still one of the goals of modern public health practice, and, although tremendous strides have been made toward this achievement, a feeling of complacency toward this disease is not justified.

Severe outbreaks of diphtheria occurring in various countries of Europe during the past fourteen years have been reported in the literature.[1] The therapeutic value of antitoxin in these instances was disappointing inasmuch as the so-called gravis form of diphtheria prevailed. It is entirely possible that similar outbreaks may occur in this country during the postwar period.

During the period July 1, 1941, to June 30, 1942, diphtheria outbreaks were reported from Lenawee, Oakland, Saginaw, and Clinton Counties in the State of Michigan.[3] The most severe outbreak occurred in Lenawee County where a migratory labor camp and a school were involved. The labor camp was made up of sugar beet agricultural workers, the population of which numbered 250. The total epidemic consisted of seventeen clinical cases of diphtheria, four of which died. Fourteen carriers were identified.

During the spring and summer of 1943, a rise in the incidence of diphtheria throughout Michigan was noted. Nearby states reported similar upturns.

The generally accepted reason for this sudden rise in the State of Michigan is the widespread shift of population groups into industrial areas occasioned by the war. Many of these migrants have never been immunized against diphtheria.

The following report comprises the results of an epidemiological investigation of a small diphtheria outbreak which occurred in Sturgis, Michigan, during the period June 4, 1943, to July 25, 1943. The total outbreak consisted of 11 clinical cases of diphtheria, with no deaths. Seven carriers were identified.

Sturgis has a population of 8,000, and is the center of an industrial area. It is located in St. Joseph County, and borders on the Indiana State boundary line.

Diphtheria Outbreak, 1943

The cases in the table represent a group of persons with diphtheria, listed in chronological order as the diagnosis was made. The listing includes: age, sex, date of onset, diagnosis, complications, number of units of antitoxin administered, serum reaction, outcome, status of immunization, exposure to case, and source of milk supply.

In the group of eleven cases comprising the outbreak, multiple cases were discovered in four families. A study of the age groups revealed that five cases were children under eight, two were older children of sixteen and seventeen and four were adults. Nine of the eleven cases were females. The seasonal distribution of the cases was unusual in that the outbreak occurred during the summer; ordinarily the peak incidence of diphtheria is reached in late autumn and early winter. All cases were diagnosed as the pharyngeal form, the diagnosis being based on the presence of a

DIPHTHERIA OUTBREAK IN STURGIS, ST. JOSEPH COUNTY, MICHIGAN, 1943

Case No.	Name	Address	Age	Sex	Onset	Diag. Form Date	Complications	Antitoxin Units Dates	Reaction	Outcome	Status of Immunization	Exposure to Case	Source of milk supply	Remarks
1	R.T.	2M St.	29 yr.	F	5-31-43	Pharyngeal 6- 4-43	None	20,000 6- 4-43	Yes	Recovered	No record	No history	A Diary	Patient employed in doctor's office
2	E.B.	4A St.	2 yr.	F	6- 5-43	Pharyngeal 6- 7-43	None	20,000 6- 7-43	No	Recovered	Not immunized	Yes	Private	
3	C.A.W.	4A St.	10 mo.	F	6-10-43	Pharyngeal 6-12-43	None	20,000 6-12-43	No	Recovered	Not immunized	Yes	Private	Relative of E.B.
4	J.F.	6B St.	40 yr.	F	6-10-43	Pharyngeal 6-14-43	None	20,000 6-14-43	No	Recovered	No record	No history	None	
5	J.S.	8C St.	2 yr.	F	6-23-43	Pharyngeal 6-25-43	None	30,000 6-25-43	No	Recovered	Not immunized	No history	B Dairy	Sister of M.S.
6	M.S.	8C St.	5 yr.	F	6-23-43	Pharyngeal 6-25-43	None	20,000 6-25-43	No	Recovered	Not immunized	No history	B Dairy	Sister of J.S.
7	W.S.	8C St.	26 yr.	F	7- 4-43	Pharyngeal 7- 5-43	None	20,000 7- 5-43	No	Recovered	No record	Yes	B Dairy	Mother of M.S. and J.S.
8	M.M.	10D St.	40 yr.	F	7- 2-43	Pharyngeal 7- 6-43	None	20,000 7- 7-43	No	Recovered	No record	No history	Private	Mother of W.M.
9	W.M.	10D St.	16 yr.	M	7- 2-43	Pharyngeal 7- 6-43	None	30,000 7- 7-43	No	Recovered	No record	No history	Private	Son of M.M.
10	P.G.	12E St.	17 yr.	M	7- 8-43	Pharyngeal 7-12-43	None	20,000 7-12-43	No	Recovered	No record	No history	C Dairy	
11	I.G.	12E St.	8 yr.	F	7-23-43	Pharyngeal 7-25-43	None	20,000 7-25-43	No	Recovered	Immunized	Yes	C Dairy	Sister of P.G.

diphtheritic membrane confirmed by bacteriological examination of discharges. All received a minimum of 20,000 U. of antitoxin shortly before or just as soon as the diagnosis was made. R. T. experienced a severe reaction in the form of serum sickness one week following the administration of antitoxin. Only one case gave a reliable history of successful immunization against diphtheria. Four cases gave a definite history of exposure to a previously diagnosed case. All cases reported a different source of milk supply.

One week following the administration of 20,000 U. of antitoxin, R. T. developed a severe case of serum sickness. She first complained of hives for two days and then developed the following signs and symptoms: sudden prostration with generalized edema of the face and extremities, generalized pain in the extremities and back, flushed face, and distant weak heart tones. She was hospitalized for a period of 4 weeks and recovered approximately two months following the onset of the reaction.

All cases recovered without any intervening complications.

Discussion

Epidemiological investigations were made on each case reported in order to determine, if possible, the source of the infection. A search was made for the following possible sources:

(1) missed, mild, or unreported cases, (2) carriers among the household contacts by means of nose and throat culture surveys, (3) milk supply.

Case 1.—R. T. was employed in a local physician's office when she contracted the disease. She could give no history of exposure to a known case, but a possible source of her infection could be an unidentified carrier or a mild missed case.

Cases 2 and 3: E. B. and C. A. W. represent two children in a family of nine. One of the children, supposedly free from diphtheria, suffered a chronically infected nose before the onset of E. B.'s and C. A. W's illness. This condition was found to be diphtheritic, the diagnosis having been confirmed by a positive nose culture. It is believed that the source of the infection in E. B. and C. A. W. is the mild missed case of nasal diphtheria within the household.

Case 4.—J. F., an adult, gave no history of exposure and did not use milk. The source of her infection remains undetermined.

Cases 5, 6, and 7.—J. S., M. S. and W. S. represent a mother and her two children, all living together. No history of exposure to a case was elicited, but the third child in the family proved to be a carrier. It is believed that J. S. and M. S. contracted the disease from their carrier brother, and that the infection was passed on to W. S., the mother, while she cared for J. S., the baby of the family.

Cases 8 and 9.—M. M. and W. M. are mother and son, living together with the other members of the family. The remaining four members of the family were identified as carriers. It is believed that M. M. and W. M. contracted the disease from a carrier-member of the family.

Cases 10 and 11.—P. G. and I. G. are brother and sister, living together. I. G. contracted the infection from P. G., but P. G. gave no history of exposure to a case. Following the onset of I. G.'s illness, one other member of the family was discovered to be a carrier. The source of P. G.'s infection remains undetermined.

The fact that all cases used a different milk supply probably eliminated this possible source of infection.

It may be said that no common source of infection could be attributed to all eleven cases, but a total of seven carriers were identified.

One case, I. G., gave a history of previous immunization, but it is a known fact that cases of diphtheria may occur even in those inoculated. The failure to immunize successfully after inoculation has been reported by Park,[4] and this is not surprising because even an attack of the disease does not confer permanent immunity.

Control Measures

The control measures instituted to check the spread of the infection were as follows: (1) quarantine of cases until two negative nose and throat cultures were obtained no less than twenty-four hours apart, (2) release of carriers when two consecutive cultures from the nose and throat, taken at intervals of not less than twenty-four hours, were negative, (3) close observation of extrahousehold contacts, (4) public health nursing service to the families, (5) checkup of milk supply.

The outbreak served as an impetus for an aggressive diphtheria immunization campaign in the city of Sturgis, and resulted in a marked increase in the number of immunizations done during this period. It afforded a grand opportunity for educating the public to the value of diphtheria immunization. Parents were urged to have their children immunized by the family physician.

The parents of those cases having enlarged tonsils were urged to have them removed after convalescence, as these cases may become convalescent carriers. As an attack of the disease does not confer permanent immunity, artificial immunization was also advised.

Diphtheria and poverty are often associated, and the disease commonly affects the children of poor white parents. Accordingly, improved housing conditions and sanitation are important in its control.[2]

Summary and Conclusion

1. The report of an epidemiological investigation of a small diphtheria outbreak in Sturgis, St. Joseph County, Michigan, has been presented.

2. The outbreak comprised eleven cases, all of whom recovered.

3. A source of infection common to all cases could not be determined; however, four cases were traced to carriers, two to a missed case, two to a diagnosed case, and in three cases the source remained undetermined. Seven carriers were identified.

4. This outbreak demonstrates the need for continued long-range immunization programs.

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Methods of Personality Study in Relation to Medical Practice

By John C. Whitehorn, M.D.
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Personality, as the organized system of attitudes through which one handles interpersonal relationships —well, poorly or perniciously—may greatly affect the organ systems through chronic and repetitive anxiety states and conditioned reactions. How may one recognize and characterize the personality trends disruptive of bodily health, in a manner useful in treatment? Discussion of the attitude examination and the use of the interview, social history and special techniques and tests in evaluating personality trends and their modifiability.

■ In the world of medicine today there is a very widespread and very active interest in the influence of emotion in matters of health and disease. The war has heightened this interest, not merely by producing a considerable crop of anxiety reactions, but by highlighting certain conditions, like peptic ulcer, in a manner to emphasize that emotional reactions sometimes ruin one's health. Just as the *germ* theory of disease served to generate, during the nineteenth century, a systematic development of medical science and of preventive medicine, so there are many indications now that the next great medical campaign for health is to be fought against *emotional factors* in disease. We need, of course, to recognize that emotional factors may be a powerful force for health, too. Experience tells us that many persons thrive under conditions of emotional stimulation which seem to blast or wither their less fortunate companions. We know that emotional maturity is only gained through emotional experience. We know enough of such matters to recognize that the individual *personality* is the principal determinant of such issues. We need to know much more in detail concerning the *manner* in which emotional experience is integrated and managed by the individual for good or for bad.

Read at the Third Postgraduate Conference on War Medicine, the Seventy-eighth Annual Session of the Michigan State Medical Society, at Detroit, September 23, 1943.

I have undertaken to discuss with you today the special subject of *methods* in this general field of personality study. I hope to say something of potentially practical value to every medical man. I think it is safe to say that there is no medical man, carrying the responsibility for the care of patients, who does not have some medical problem on his hands which requires for its proper management some solution of a personality problem. To appreciate that the patient *is* a person, and to deal with the patient *as* a person —these are for many physicians natural and automatic aspects of the medical profession, simply a part of life as a physician. Such natural common sense is not, however, the fortunate possession of every physician. Even when present it can be improved by the insight and the methods developed in psychiatry.

We need not for our present purpose recapitulate the whole range of psychiatry, but I do wish to characterize and discuss three levels of psychiatric study which I will call, for convenience, formal, epithetic and thematic.

The most elementary and superficial level of psychiatric study is what I have called here the formal. All of you have had some contact with that type of work and will recognize promptly what I mean. I mean the symptomatologic description, analysis and delineation of types of insanity. These types were usually conceived of as specific mental diseases, for example, involution melancholia, dementia praecox, manic-depressive insanity, general paresis, paranoia, et cetera. Such study at its best performance called for a close examination of the patient, and a meticulous scrutiny of his behavior to detect whatever features were definitely abnormal or pathologic, and then the comparison and evaluation of such "positive findings" to arrive at a classification or diagnosis. In the keenest development of psychiatry at this level, as exemplified in Kraepelin's clinic, there was a sharp distinction between form and content. For example, in regard to hallucinations, the occurrence of hallucinations was primarily to be established as a definite abnormality of psychic function, characterized as visual, auditory, olfactory, et cetera, with, perhaps, some consideration of the degree of absurdity, but with the definite understanding that the content was not important. It did not matter what the voices said.

As a matter of history, it so happened that the

period of high interest in this formal descriptive level of study was contemporaneous with a fairly elaborate development of mental status outlines and forms for examination and recording. It is perhaps inevitable that such parallelism would occur. Systematic records began to have prestige value, and a good psychiatric training came to be almost synonymous with the ability to write up "a full mental status report." One result was to fix in fairly rigid form the style of recording the psychiatric examination of the patient in terms of a formal résumé of abnormal items. Some of the remote consequences of this kind of training were unfortunate. I have had a number of internists in several cities tell me of experiences like this: "I like to keep up with the newer things, and when I saw that my colleagues elsewhere were getting real help from their psychiatric associates, I asked for consultations from a psychiatrist on some of my patients who seemed to have personality difficulties; but I just got back a report telling me how well the patient could subtract 7 from 100, that she was orientated in the three spheres, that her sensorium was clear and that no hallucinations, delusions or ideas of reference could be elicited." This was the end of psychiatric collaboration for that internist. Well, it is obvious that this type of mental status examination has little value in helping the internist to deal with the personality problems of his patients.

The second level of psychiatric study is what I have called the "epithetic," meaning by that to characterize an interest in the terms or epithets by which to designate the personal qualities of patients. "Adjectival" might be a nicer word for it. This adjectival or epithetic method of psychiatric study represented a stage of progress beyond the earlier preoccupation only with what was pathologic in the patient, and served to record the psychiatrists' growing appreciation that some attention to the wide range of human qualities and characteristics which lie within normal limits may be helpful in understanding the patients' development into full-blown mental illness. Adolf Meyer perceived in some dementia praecox conditions the influence of bad mental habits. He and August Hoch singled out one very significant characterization, the "shut-in" personality. Bleuler contributed "schizoid" and "syntonic." Jung probably scored the all-time high in popular acceptance with his fascinating dichotomy of "introvert" and "extravert." Quite recently, from a nonpsychiatric source, we hear of Sheldon's "cerebrotonic," "somatotonic" and "viscerotonic" types of personality, in association with an elegant refinement of Kretchmer's body-types.

Psychiatric interest in personality has not remained restricted, however, to this "epithetic" level of typing and classifying. The question of formal diagnosis receded to the background as the individual patient, with all the rich content of his life experience, pathologic or normal, got the main spotlight of psychiatric interest. In large measure this brought a greatly increased interest in content as distinguished from form. This was a natural development from Freud's type of intensive study, and interest was stimulated by the remarkable revelations of psychoanalytic research, indicating unexpected connections between early life experience and certain rather specific forms of character development; but the psychoanalytic school was not alone in this work. Among other workers, too, biographic attention was focused on the individual evolution of personality trends as emotionally conditioned styles of interpersonal adjustment. The importance of personal emotional insecurity in personality development was overwhelmingly well established by many studies of the behavior problems of children. The queer statements and odd behavior of psychotic patients were more intensively scrutinized for clues to the character of the patient's pre-occupations as understandably related to the issues of his pre-psychotic and post-psychotic life. It is this level of psychiatric study which I have designated as "thematic." I mean to include under this designation of "thematic" the study of the special themes of a patient's preoccupation, and also the study of personality trends as they have developed out of plastic native disposition under social pressures. Such studies depend largely upon skill in eliciting and recognizing attitudes. How is this done?

On one side the business of recognizing a person's attitudes lies so much in the realm of obvious common sense that it seems superfluous to discuss it; on another side it ties in with complicated techniques of exploring the unconscious through free association, dream analysis and the acute observation of gestures, a region in which the "personal equation" of the observer may require rather elaborate study and control. The chief reason for discussing the clinical evalu-

ation of attitudes lies in this practical, clinical importance both for the specialist and for general medicine. Physicians more and more appreciate that the presence of organic lesions does not preclude the operation of emotional and neurotic mechanisms; the patient is still a person, subject to the physiologic and pathologic effects of the clashes which may occur between poorly integrated attitudes.

It is therefore a very practical matter to inquire as to how the medical man can be helped to gain a further insight into, and some increased skill in the use of, psychiatric methodology at this third or "thematic" level, which deals with attitudes.

For their influence on health and disease there is one general class of attitudes which exceeds all others in importance—those attitudes which arise primarily out of personal relationships and which in turn determine how one relates oneself to others in subsequent experience. Man is a domesticated animal, although an imperfectly domesticated one. He finds, or fails to find, the meaning and value of life in personal relationships. It may seem otherwise at times, in individual cases—as if one fellow lived for the purpose of stimulating his palate with exquisite flavors, or another solely to accumulate wealth, or another to gain the admiration and flattery of the great outside world of strangers, to the neglect of those at home. But these apparently impersonal attitudes are in the main derivatives and residues of experiences in domestic relationships. What is of practical *methodological* significance, these more fundamental interpersonal attitudes, of which the apparently impersonal attitudes are secondary derivatives, are exhibited and available for study and appraisal in situations of a personal nature such as fall within the observation of the physician. The physician indeed has extraordinary opportunities and incentives for the study of interpersonal attitudes as they come out under difficulties. It is not a mere accident that some of the most penetrating character studies in the world's literature have been written by physicians.

As a school teacher, now, I am of course personally much occupied with the pedagogic aspects of this problem for the purpose of training young doctors for most effective service. You will perhaps pardon me, therefore, if my present discussion of this matter is contaminated by some of the dry chalk dust from the lecture room or by a somewhat dogmatic hangover from ward rounds and student conferences. In the special practice of the psychiatrist, dealing with the most serious disturbances of personality function, the study of attitudes is, sometimes and in some respects, made easier by the exaggerated intensity of the patient's preoccupation with certain personal themes. I have followed the practice, and urge upon others to follow the practice of paying special attention to the more personal features in these cases, as a source of useful knowledge regarding individual difficulties in the organization and management of the patient's attitudes in interpersonal relationships.

The most obvious demonstration of the interpersonal attitudes operating in a patient occurs in the situation labeled "misidentification"; when a patient misidentifies the nurse or doctor as a character—say husband, father, uncle or lover—significant in her past life, invests him with the characteristics of that person (as conceived by the patient), and behaves toward him in some definite pattern, affectionately or contemptuously or spitefully or with exaggerated respect, et cetera. Such a situation reveals something of the patient's sentiments toward the character so personified.

A patient's attitudes may also be inferred from other considerations regarding his or her dramatization of the hospital situation. What roles does the patient assign to the persons about, and what attitudes does he show toward the characters so cast? Does he show attachments or aversions to particular persons? In what manner, and with what changes, sudden or gradual? A communicative patient may also reveal much about his attitudes while telling about his medical history, especially about the period of transition from adolescent to adult.

The sentiments, or attitudes, recognized and evaluated by such study do not reach an unmanageable diversity. There are many recognizable repetitions. The childhood setup, with its relatively few characters, provides the paradigms for most subsequent sentiment development. One might say that the sentiments of the adult are the sediments of his childhood.

There are even quite elaborate systems of sentiment-organization which are recognizably alike in different people. There is apparently in everyone a system of loyalty sentiments and se-

curity sentiments, focused on the same persons or ideals, and knit closely together. There is a sentiment of independence, appearing in the reverse as a resentment of control, which has a marked growth in late adolescence, and not infrequently gets snarled with the loyalty-security system. There are of course innumerable complicated interactions of these main systems of security, loyalty and independence, involving the family, childhood gangs, school and college loyalties, hero worship; professional ethics and prejudices, or political, scientific and religious faiths. In the reconstructed histories of some patients one can trace the successive transference of such conflicts from one arena to another, without much growth or progress; in others, each new scene of adjustment occasions an enlargement and liberalization of the sentiments.

This discussion has dealt particularly with themes, attitudes and personality trends which are of direct practical significance in the kinds of patients we call psychotic and neurotic, but other persons do show reactions and behavior calling for a similar type of study and understanding. In particular, there are a number of widespread personality trends neatly characterized by words drawn from experience with neurotic patients. The obsessive trend and the perfectionistic attitude are well known. The sympathy-seeking attitude of the hypochondriac is often obvious. The seductive saintliness of the hysteric may be sensed by the acute observer while the patient enters the room and sits down.

Much practical help can also be gained by the physician from a consideration of the various evidences obtained regarding the patient's level of emotional maturity or immaturity. Maturity in the human being is not a fixed state of perfection, definable by a single criterion. Perhaps most of us here, being middle-aged, would regard as "emotional maturity" the set of attitudes characterizing middle age, thereby implying some superiority for attitudes of caution, tolerance and easy-going acceptance of things-as-they-are, in contrast to the impetuous urgency and competitive strenuosity of earlier years. It seems to me more useful, however, to omit the 100 per cent idea from the consideration of maturity in human development. Human nature is not like canteloupe or peach, with just one perfect moment of *absolute* maturity. Rather there are successive stages of development in interpersonal attitudes which characterize, roughly, different age groups and an individual's maturity or immaturity must be expressed as *relative* to these stages. To state or to imply that Johnny Jones, aged eighteen, is immature, is not very helpful. It is more helpful to state in which specific earlier stage of development his attitudes belong. Although there is not any generally accepted scale, one may find useful the following rough characterizations:

The *infantile* stage of emotional maturity is characterized by a complacent dependence and the expectation of infinite service and infinite tolerance from others, with petulance when not immediately gratified. (I wish to remind you in passing that there are some persons, chronologically middle-aged, who are emotionally almost infantile in this sense.)

The *childish* stage of emotional maturity is characterized by a limited range of secondary responsibility, with the expectation that this "responsibility" will be cancelled by the all-powerful parent by reason of any good excuse or ignorance. There remains, however, at this childish stage, a need for complete trust in another as the basis of any acceptable relationship. (The usual patient, when physically very ill, temporarily regresses to this childish level, and his need for complete trust in someone is a serious and important fact in medical management. During convalescence the patient, as you know, usually becomes again less trustful and more self-assertive.)

The *early adolescent* stage of emotional maturity is characterized by much concern over independence from parents and by hero-worship (that is, admiration for and devotion to extra-familial figures; frequently subject to explosive disruption), also by much interest in gangs, badges and exhibitionistic rivalries, pushing everything to extremes, and by a very self-conscious awareness of sex.

The *late adolescent* stage of emotional maturity is characterized by a "sophistication" pose, a "sophomoric" attitude, or a "line" of chatter, witticism and wise-cracks, whereby an appearance of greater maturity is sought. There is a tendency toward extreme idealism or cynicism or an idealization of aggressively strenuous competition, with much preoccupation with personal independence.

Our American culture sets a high value upon the "independence" and strenuosity characteristic

of this stage and so tends to perpetuate the late adolescent style of emotional attitudes into adult years; nevertheless most Americans, as they advance into the twenties and thirties become comfortably reconciled to the practical realities of interdependence in economic and professional matters, lose some of the emotional urgency of competitive striving and accept candidly their own limitations and the limitations of others without feeling necessarily defeated thereby.

It is not an easily described clinical task to evaluate a patient's level of emotional maturity. In ordinary clinical work, however, this task is pointed up in a practical way by making this evaluation of maturity in respect to the outstanding feature of the patient's life situation, which is brought out by considering the theme of his main preoccupation.

In this discussion of the evaluation of levels of maturity and in this general presentation of the thematic level of psychiatric study, I have given little attention to the sex problems, and patients' attitudes thereto, which are a prolific source of anxiety and maladjustment. My neglect of this topic has not been due to any feeling that it is unimportant, but rather to the special difficulties which beset the evaluation of patients' attitudes regarding the sexual life. It is customary, in these "modern" times, for those in the medical profession to congratulate each other upon the liberation from previous taboos on the discussion of sex topics. But it has been my observation that many a young doctor, quizzing a patient in a so-called "objective" fashion down to the last intimate detail of sex practices, has failed very thoroughly to catch the emotional implications of the patient's attitudes in this field and has furthermore raised such a wall of emotional reserve as to block seriously his further emotional usefulness to the patient. I have therefore often been driven to think that our vaunted "objectivity" about sex is a false front. It would be silly to revert to a Victorian conspiracy of silence about sex, but it is exceedingly important to appreciate the individual patient's emotional tolerance for the discussion of personal sex problems, to respect his or her reticence and, above all, to provide time and opportunity for the patient's spontaneous self-revelation whereby one can sense implicit attitudes.

Ladies and gentlemen, I have been trying to present some of the leading concepts and practices of psychiatric study at the thematic level, as a method of personality study. This method depends primarily upon a shrewd and skillful use of the *interviews* between physician and patient, bolstered by other aids to *biographical* study.

Some of the *special techniques* of personality study should be mentioned. High on the list would be the psychoanalytic procedure of free association, through which much information has come to light regarding the emotional attitudes and personality trends which may have impelled the patient toward one or the other of the recognized psychosomatic illnesses, such as asthma, spastic colitis, hypertension, peptic ulcer.

The Rorschach experiment has gained much repute as a special method of personality study. What one reports seeing in a series of ink blots reveals in an extraordinary way the style of one's approach to other situations. This example of the use of unorganized stimuli, to which there is no "correct" response, permits and even solicits the spontaneous organizational reactivity of the subject and gives more abundant opportunity than do question and answer tests for the exhibition of personal characteristics.

We must recognize, of course, that a psychiatrist who is endowed with time, and assistants for research, has opportunities for such study of patients vastly greater than anything practicable for the regular physician. But other physicians also have two exceedingly good opportunities to size up the attitudes of the patient. One is the history-taking interview and the other is the physical examination. These two may often be combined, to their mutual improvement, and they may be combined with this attitude-examination, with still further improvement. One does not expect, of course, that the medical student, at the completion of his work for the degree, will be highly skilled in any of these three arts, or their combination, but it seems reasonable to try to help him get a basic orientation which will make him capable of considerable future self-development in the recognition and evaluation of patients' attitudes.

In attempting to train students in the attitude-examination, it has not seemed wise to prepare a routine outline or series of questions. One of the essentials of a good attitude-examination is a degree of freedom which permits and encourages the patient's spontaneity. An understanding

of the more elementary principles of dynamic psychopathology seems a better guide than any special outline. Nevertheless, a few pertinent reminders may be of use.

1. First and probably most important of all, the chief complaint of the patient should be recorded in his or her own terms. The pernicious practice of translating the chief complaint into medical jargon may eliminate one of the most useful cues to the patient's attitude about this distress or disability.

2. Note the patient's manner of recounting his symptoms. Does he proceed with an air of all-absorbed interest, dramatizing pains and disabilities and dwelling upon them in an appeal for sympathy? Does he bring a piece of paper with detailed notes? Does the story of his illness have to be dragged out of him? Does he meet questions with hair-splitting qualifications or arguments? Does he appear indifferent to grave disabilities? Wherein does he seem to guard most carefully his self-respect?

3. As he tells about the course of his illness, note how the patient refers to the effects of his illness on his responsibilities or on his home life. Note his attitude toward those who have suffered or been inconvenienced by his illness, as compared with his own distress. In what way may his illness be providing a secondary gain?

These fragmentary suggestions are not offered as an outline of examination but as hints to help the doctor gain some impression of the patient's attitudes toward his illness, toward himself, toward the doctor (and hospital or clinic), and toward his responsibilities and other persons concerned.

The physician who can recognize and evaluate with reasonable correctness these personal attitudes of his patient, and who has at his command a fair working knowledge of psychopathologic dynamics, will have gained thereby a point of view on his patient's personal attitudes in positive terms. This appreciation of attitudes does not exclude organic pathology, nor does it depend upon the diagnosis of a functional disorder by exclusion of organic lesions. Even when the patient's attitudes are pathognomonic of one of the classical psychoneuroses, it is still important to know if he has some organic disease. Hypochondriasis does not immunize to cancer, nor does hysteria immunize to brain tumor. Conversely, the discovery of ulcerative colitis, of mitral stenosis, of undulant fever, or even of an obvious hernia, does not of itself eliminate from medical consideration the attitudes and patterns of personality reaction which may be the factors hindering treatment, or limiting recovery or impelling the patient toward an unnecessary and miserable second-rate invalid adjustment in life. For the diagnostician to miss an organic lesion has been, quite properly, an occasion for some professional disgrace; now, with a more widespread understanding of the emotional forces which produce ill health, with a knowledge of how to examine for pathological attitudes and reactions and with an increased appreciation of psychotherapeutic resources, it should become a comparable professional disgrace to overlook personality disorders.

Even when the patient's illness appears altogether "functional" in origin, as the phrase goes, the physician who has taken advantage of his opportunities to evaluate the patient's attitudes will find, I think, that he has not driven the patient out on a diagnostic limb simply to be cut off and dropped into the lap of another specialist, but that he has established some common ground of respectful mutual understanding by which he himself may be therapeutically useful. If psychiatric referral proves necessary, and feasible, the physician can more constructively aid the patient to seek and accept specialized psychiatric assistance through having established this common ground of respectful mutual understanding.

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REINFUSION OF RED BLOOD CELLS

The practical aspects of the routine reinfusion of red cells may now receive some consideration. . . . In blood banks which draw their donors from a population having to travel considerable distances to the bank, the drawn blood could perhaps be immediately centrifuged and the cells reinfused on the same day. This would entail a somewhat longer wait but might eliminate the problem of post-transfusion syncope (fainting) . . .

It is pointed out in the conclusions that the investigators have projected a study "to determine the natural pacemaker of the frequency of plasma donations and thus to explore the feasibility of obtaining plasma at more frequent intervals than the prevailing eight-week minimum."—*Northwest Medicine,* March, 1944.

Palindromic Rheumatism (Hench's Disease)

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A report of a case of palindromic rheumatism, a disease of multiple afebrile attacks resembling acute arthritis, periarthritis, and para-arthritis and which is characterized by pain, swelling and temporary disability of generally one, occasionally several, small or large joints in an adult. Despite hundreds of attacks in some patients, and thousands of attacks in aggregate, no evidence of permanent disability was demonstrable. The disease appears to be self-limiting in any single attack and may follow a similar or previous pattern in repeated attacks.

F. S., a white male patient, aged forty-three, was admitted to the Henry Ford Hospital on October 18, 1941, complaining primarily of right lower quadrant abdominal pain. The white blood count was 16,500; there was no fever. Appendectomy was performed the day of admission by a resident through a right rectus incision. Definite pus was found in the appendix and abdominal exploration revealed no other abnormality except some hardness of the head of the pancreas. The blood diastase was 20.1 the day of admission, 39.9 the day after operation, 32.5 on October 23, and 20.8 on October 26, 1941.

On October 31, 1941, the patient complained of a tender swelling of the first interphalangeal joint of the right index finger. The skin over this joint appeared tense and pale with no sign of involvement of other joints. There was no sign of lymphangitis or lymphadenitis. On further questioning, the patient stated that he had had similar attacks of pain and swelling in various joints since the age of eleven years. At that time he had pulled a poison ivy vine from a tree and the following day his hands began to itch and have been itching and swelling periodically since. Within the same week his feet began to swell and itch. From that date until 1936 he had had biweekly swelling of the different joints of the feet, with occasional periods of daily attacks. He had had no attacks involving the feet since 1936 although he had received no treatment for this condition, except his own immersions into hot salt water, which relieved the itching but not the swelling nor the pain and tenderness.

The patient's hands, however, continued to swell and become painful, the affection usually involving individual joints, and most frequently the terminal interphalangeal joints. The larger joints of the arms and legs have never been involved. The attacks in the hands are more frequent than ever before and now average about four per week, occasionally every day, sometimes twice per week. The longest single attack lasted two days and one night, while the shortest attack was of two hours' duration. The attacks let up spontaneously and go as suddenly as they begin. They usually appear in the late afternoon and are worse at night. The patient has noticed no general symptoms. He has not consulted a physician for this trouble at any time. He states that the affected joints turn white when they swell. The only relief obtainable is for the itching which is benefited by immersion in warm salt solution. No swelling, discoloration, deformity of the joints, or limitation of motion has been noted between attacks.

A careful study of the patient's general history indicated no evidence of allergic background in his family. He himself presented no history of migraine, asthma or hay fever and no sign of reaction to external agents except that occurring due to the poison ivy at the age of eleven years.

Physical examination after recovery from the appendectomy revealed a healthy middle-aged male. No abnormality was noted between the attacks of rheumatism except dental caries, which the patient stated were only of a few years' duration, and chronic tonsillitis. The joints were examined carefully and there was no evidence of deformity or pathological change.

The laboratory data included negative blood tests for syphilis and urine examination which showed: specific gravity 1.024, alkaline reaction, no sugar and no albumin and microscopic findings of amorphous phosphates four plus and occasional leukocytes. The blood count showed hemoglobin 14.5 gm.; red cell count 5.46 millions; white blood count 16,500 (9,200 two days after operation), and differential at the time of the elevated total white blood count: polymorphonuclear neutrophiles 89 per cent, small lymphocytes 6 per cent, large lymphocytes 3 per cent, monocytes 1 per cent, and juveniles 1 per cent. The nonprotein nitrogen was 24.0, icteric index 8.2, and the diastase 39.9, the latter decreasing to 20.8 eight days after operation. Two days after operation the ascorbic acid level in the blood was 0.1 and 300 mgm. of vitamin C was given t. i. d. beginning October 26. The serum albumin level was 3.28 and the serum globulin 2.71 gm. per 100 c.c. The patient remained in the hospital twenty-seven days and was entirely fever free the last thirteen days.

Summary.—A case is reported with symptoms of thirty-two years' duration, similar to those presented by Hench and Rosenberg and named by them Palin-

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dromic Rheumatism. The past history of this patient is that of an average healthy male adult with the only unusual feature being the many and frequent attacks of pain and swelling in the joints of the hands and feet, the beginning of which he associates with the contact with "poison ivy" vines. Physical examination after recovery postoperatively from an appendectomy is negative except for dental caries of a few years' duration and slight evidence of chronic tonsillitis. There is no evidence of deformity or limitation of motion in the joints involved. The patient was last seen on November 24, 1941, thirty-seven days after operation. He was asked to return for further studies but did not do so.

Comment

This patient was in the hospital with the diagnosis of the rheumatic attacks in doubt when the senior author (H. N. H.) attended the meeting of the Central Society for Clinical Research in Chicago, November, 1941. The description given the syndrome of palindromic rheumatism by Dr. Hench at that time was so dramatic, that the present case was immediately recognized as belonging to that classification. In this paper (Hench, 1941, and Hench and Rosenberg, 1942) a study was made of thirty-four cases of palindromic rheumatism seen at the Mayo Clinic. Features of the disease are multiple afebrile attacks of acute arthritis, periarthritis, and sometimes also para-arthritis, with pain, swelling, redness and disability of generally one, sometimes several, small or large joints in an adult of either sex. Follow-up data in twenty-seven of the thirty-four cases indicated that, although spontaneous cure occasionally occurred, the condition tended to continue with its pattern relatively unchanged, but permanent crippling did not occur despite thousands of attacks suffered during a total of three hundred and seven years of illness (two hundreds and forty-two years before plus sixty-five years after admission). In another paper (Hench and Rosenberg, 1941) these Mayo Clinic authors described the syndrome more fully. They applied the term "palindromic" which simply means "to recur" or "to return" and which is derived from a Greek word meaning literally "to run back."

Since this classic group of papers by Hench and his associate, L. D. Thompson (1941) and Mazar (1942) each reported one case while J. L. Thompson, Jr. (1942) reported two cases. The addition of our case which seems to fit the description of the thirty-eight others brings the total to thirty-nine.

Summary

1. A case is reported of recurrent afebrile rheumatic attacks involving especially the small joints of the fingers and toes of a forty-three-year-old white man. This case seems to fit the description of palindromic rheumatism made by Hench and Rosenberg in 1941.

2. Adding our case to the thirty-eight that we were able to collect from the literature, this brings the total of cases of palindromic rheumatism on record to thirty-nine.

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Wartime Obstetrics

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Personnel deficiencies are dictating many attempts to reduce the professional care of obstetric patients to the essentials consistent with safety for mother and baby. Luxury items must be eliminated, for time must be saved.

An attempt will be made to evaluate prewar ideas of adequate obstetric care and treatment in terms of their essentiality—what must be retained? what can be eliminated? how can available professional skills be spread thinner without undue additional risk? how do newer techniques fit into the theme of simplification?

■ THIS title was not intended to suggest that war brings any change in the objectives of obstetric care, but rather that it may alter the means by

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which these objectives are obtained. We must still aim at preserving "the life, health, and happiness of the mother and her child," and must not permit the present shortages of personnel and equipment and the significant rise in the birth rate to thwart this aim. I would like to mention some things which can compensate for this awkward situation as efforts at "streamlining obstetrics," but the usual connotation of that phrase emphasizes the luxury of the streamliner rather than the speed and safety of its progress. Wartime obstetrics should be stripped of its luxury items in the interest of speed and safety. Nothing essential should be omitted but the nonessential should be discarded. Perhaps we should call it "simplified" rather than "streamlined."

Prenatal care can scarcely be simplified except by the elimination of unnecessary laboratory work. The routine clinical observations on weight, blood pressure, urine, and general observation of the progress of the pregnancy would seem essential, whereas the withdrawal of blood for serologic study is demanded by many state laws. On the other hand, there is no good reason for routine blood studies when the hemoglobin concentration can be estimated from the appearance of the conjunctivæ as closely as by most clinical hemoglobinometers. Old-fashioned pelvimetry combined with intelligently performed abdominal and rectal palpation can well replace costly roentgen pelvimetry except in rare cases. In fact, the important size relationship between the fetal head and the pelvic inlet can be determined manually with conspicuous accuracy.

The gradual trend away from home confinement and toward hospital delivery has evidently been accelerated by the present emergency, since the latter takes less of the physician's time and permits him to carry on other professional duties while cervical dilation is proceeding under the watchful care of a nurse. The demand for obstetric beds has in many communities exceeded the supply and has resulted in two generally acceptable variations from usual practice—reduction in the length of post-partum hospitalization and putting two beds where there was only one. The time-honored ten days in bed after delivery are certainly not necessary for a safe and smooth convalescence, but there is no good evidence as to where the minimum may be. For some years, our normal puerpera have been allowed up six days after delivery and are discharged two days later if they reside in the city or three days later if they live at some distance. Undoubtedly, an occasional patient does develop some late-appearing puerperal infection—parametritis or thrombophlebitis—after discharge, but the risk is very slight. We have had little experience sending such women home in an ambulance three or four days after delivery but are inclined to doubt that serious consequences will develop more than rarely. The one obvious disadvantage of early dismissal affects those women who prefer to suckle their children. Even after a week it may be impossible to determine whether the milk supply will be adequate, and one is confronted with the choice of sending them home in hopes that things will work out satisfactorily or of detaining them for a few days.

The average single hospital room is large enough to accommodate two beds—a fact which has in part solved our own problem. A portable screen placed between the beds affords some slight privacy but most women prefer to eliminate it. There are certain advantages to putting together two women who have delivered the same day. Obviously, the occasional seriously ill patient will require a separate room.

When objection is raised to such crowding, the woman, or more frequently her husband, is simply told that they are lucky to have any accommodations. Special nurses are a luxury that should not be tolerated except in extreme cases. Moreover, when nurses for general duty are scarce, all special nurses should be required to serve a day or two of general duty for each week they serve as "specials."

Overcrowding in nurseries appears also to be not so serious a situation as we have been led to believe, provided reasonable but not elaborate care is provided and there is available an isolation nursery for those infants with even suspicious contagious lesions.

It is in actual care during labor that modern obstetrics has become luxurious, with a resulting expenditure of professional time out of proportion to the results obtained. I refer, of course, to the widespread and amazingly successful efforts to make childbirth "painless" through heavy drugging with one preparation or another. These various techniques have one thing in common—they demand the close supervision of trained professional personnel if the safety of mother and child is to be assured. The question can naturally be raised as to whether the time will not soon come when we must decide whether our nursing and

medical skills can be better employed in some more fundamental activity. I would not have you think that I oppose the employment of pain-relieving procedures, but rather that I propose the utilization of the less technical and probably less effective but essentially safer methods of producing incomplete but still satisfactory analgesia. I have never been convinced that the demand for painless parturition originated with our child-bearing women. As I have watched it develop since the days of "twilight sleep," it has appeared to be activated by a spirit of professional competition. If this evaluation is correct, then possibly our sins of commission are overtaking us and may make for less competitive and more reasonable analgesia. There is no good reason to believe that incomplete analgesia or amnesia will not be acceptable to most women as a wartime sacrifice, and it will help to relieve the professional burden. Tollefson in a recent analysis of obstetric nursing activities at the California Hospital in Los Angeles found that each delivery required sixteen hours of nursing time, and that four and one-half hours, or 28 per cent of that time, was spent "watching patients under analgesia."

With the increasing scarcity of trained anesthetists, our ideas on obstetric anesthesia may need revision to the point where the nurse or the physician himself will function unassisted. Drop anesthesia with chloroform, ether, or the newer vinethene can be entrusted to the nurse under supervision of the operator in spontaneous deliveries and in the simpler operative procedures, as was the custom a generation ago. Perineal block and caudal anesthesia can be carried out by the physician alone with a high percentage of satisfactory relief. Such changes are not what we desire, but would appear safer than turning a tyro loose with the complicated machines employed in administering the preferred anesthetic gases. Over approximately the past two years, we have used chloroform and vinethene in many uncomplicated deliveries with no serious sequelæ.

Many simplifications of postpartum care have been developed to reduce the time demands on the nurses, and can be recommended. The routine employment of abdominal and breast binders can be abandoned, and their use restricted to those presenting some indication such as lax abdominal wall or heavy pendulous breasts. The common practice of keeping an ice-cap on the lower abdomen for the first twenty-four hours to promote uterine contractions and reduce afterpains can scarcely be defended; its elimination saves valuable time and appears not to increase the patient's discomfort. The routine administration of ergot preparations for the same purposes is probably useless.

Care of the perineum with old-fashioned pitcher douches of some antiseptic solution every so many hours and after urination and defecation is a needless gesture. Equally satisfactory results can be obtained by cleansing the area with soap, water, and wash cloth from one to three times daily depending upon the amount of the lochia. After the first two or three days the operation can be safely entrusted to the patient, who can be relied upon to treat any stitches more gently than even the most experienced nurse. The use of absorbent pads under the buttocks in place of the venerable vulval pads saves some expense and is more consistent with proper treatment of a wound since there is nothing to become entangled in, and to pull upon, the suture ends.

The normal puerpera should not be treated as an ill individual, but rather as one who is resting from a strenuous physiologic experience—labor—and is probably launching upon another longer experiment—suckling her child. The final objective of puerperal care should then be to get her in good physical condition as soon as possible. She should be encouraged to move around in bed, to feed herself, and, after the first day or two, to bathe herself. If the child is bottle-fed, the mother should carry out the feedings, except possibly that in the middle of the night. She needs the experience rather than the nurse. Regular diet can be given beginning at the next mealtime following delivery. The nutritionist appreciates the elimination of liquid and soft diets from the routine care.

The breast tray represents a most unconscionable waste of time, and yet many hospitals still adhere to the belief that it maintains some miraculous protection for the nursing mother. A few moments' application of boric acid solution is held to transform a hazardous experience into one which is safe and enjoyable. Long experience has shown that there is no increase of fissures or of mastitis when the nipples are treated with kindly neglect and are permitted to function naturally. Definite lesions must obviously be treated but it is my belief that little can be done to prevent their development; certainly the breast tray is ineffective.

Tollefson found that each baby in the nursery

requires slightly more than two hours of nursing attention daily, or, to put it differently, that a nurse's day of eight hours provides twenty-four-hour care for only four babies. Diapering, feeding, and bathing consume approximately 50 per cent of the total time. Clearly nothing can be done to reduce the first, but the two latter procedures may be made less time-consuming. Breast feeding eliminates many operations such as formula making, bottle and nipple care, and milk warming, and should be encouraged. If bottle feeding is necessary, the mother should carry the feeding burden. Bathing with an antiseptic oil is less time-consuming than soap and water baths, and probably better for the baby. Routine irrigations of the eyes and swabbings of the mouth with boric acid solution serve no useful purpose, and may actually increase the incidence of nonspecific conjunctivitis and of thrush, besides wasting valuable time. Taking of rectal temperature once daily, except possibly during the first twenty-four hours is probably sufficient unless the baby is not doing well. Weighing before and after nursings on either the fifth or sixth day, together with the regular morning weight at the time of the bath, should indicate the nutritional status of the child and the sufficiency of the mammary gland output.

It has been our experience that much of the elaborate nursery routines designed to reduce infections among the new-born is unnecessary provided that means are available for maintaining a relative humidity of approximately 50 per cent. During the summer months nature usually provides such atmospheric conditions, but in the colder portions of the year special devices must be installed to increase the humidity. Under conditions of controlled humidity we have eliminated face masks even in the premature room, without any noticeable increase in respiratory disease. All persons with respiratory infections are, of course, excluded from the nursery. The nurses are not required to wear gowns. Simple hand washing is required between babies, but frequently even this is overlooked. Such simplification offends our meticulous confreres, but avoids a very considerable expenditure of time and effort.

Undoubtedly, there are other ways of conserving the time of trained personnel, which will become evident when any hospital staff analyzes its routines. Especially in open hospitals without a functioning obstetric staff, too much attention may be given to the foibles of the various visiting physicians, with the result that there are many individual routines and confusing pet techniques to complicate nursing care. Frank and open discussion will usually permit development of a middle-of-the-road routine, that can be adopted as standard for all. Another useful proposal involves the training of lay women to act as "ward secretaries" to do the charting, to answer telephone calls and run errands, to make out the many lists of patients demanded by most hospital administrators, to complete birth certificates, and to handle other clerical tasks traditionally within the nurses' realm. The use of Red Cross Nurses' Aides for giving baths, making beds, and doing other simple professional tasks is widely accepted and can well be expanded.

The entrance of the federal government into the field of obstetric care has raised certain problems of interest to us all. That involving the direct payment of the physician by the State Health Department appears to me to be of minor significance, although I understand that your Society has opposed it as representing a wedge that may lead to the more general employment of physicians by the government. Actually, what difference does it make whether the beautiful young wife or the rich old uncle pays your delivery fee, when the rich old uncle alone has the cash with which to pay you? The wife might squander the money on something else and leave you unremunerated, but the old uncle always pays, albeit at the expense of the writer's cramp you develop from filling out forms.

To me, it is far more important that the rate of payment has been set so low, and that congressional amendment to the original bill has completely erased all the standards for giving obstetric care that had been developed so carefully over the years by the Children's Bureau. The first probably offends chiefly the obstetrician who has grown hoarse contending that a well-conducted and successful delivery should be able to compete financially with a fifteen-minute appendectomy. In any event, there is good evidence that the twenty-five dollar delivery and the thirty-five dollar complete obstetric care fees are popular with the profession. I am told that in one midwest city near a large army camp the physicians had refused to care for army wives. The station hospital, with two or three certificated obstetricians on the staff, completed arrangements for giving obstetric service to these women just as the federal appropriation became available. The

local medical men then decided that they could easily handle the additional clinical load and demanded, successfully, that the post facilities be not used. In other words, money talks, and sure money, even thirty-five dollars, is far from being a whisper.

The amendment, which apparently authorizes payment of the standard fees to osteopaths and chiropractors, and even to midwives in certain states, has all the earmarks of legislation which was viewed only from the political angle. Obviously, it puts at the same level all individuals who are licensed by the state to attend parturient women. What effect this will have upon maternal and infant mortality rates can only be conjectured, but a reduction can scarcely be anticipated.

Clearly, "wartime obstetrics," with its professional, financial, and political facets deserves more time than I have been allotted, but I trust that I have stimulated thought without arousing any personal antagonism. The primary obstetric responsibility of those of us who are fortunate or unfortunate enough not to be with the armed forces should be (1) to simplify our obstetric routines by elimination of nonessentials in order to make the available trained personnel adequate to protect the life and health of our mothers and their children, and (2) to direct the seemingly inevitable encroachment of government into obstetric practice so that the least possible harm will be done, making the welfare of the patient the criterion by which all innovations are judged.

An Interlocking Finger Bandage Which Needs No Anchor

By H. H. Pool, M.D.
Pontiac, Michigan

B.A., Ohio Wesleyan University, 1909; M.D., Western Reserve University, 1918; Postgraduate University Michigan 1925-27; Diplomate American Board of Radiology, 1937; Member American College of Radiology, 1940.

In my childhood we usually figured that a finger bandage would probably stay on about an hour, if we were careful. I found the same difficulty later in medical practice unless adhesive was used or the bandage was anchored to the wrist. I then tried an adaptation which I found almost universally satisfactory; this bandage cannot unwind and on the average finger it is almost impossible to remove it without untying. It is particularly useful to persons who are actively using the hand.

The bandage is applied in this manner: After the dressing is in place I usually cover the end of the dressing with a piece of 3-inch bandage which would reach well up on the finger. This gives a smooth end so that overlapping is not necessary. The free end of the bandage is left some 6 inches long. This is held by the patient or the physician with the first round of the bandage passing just above it. It is then lowered parallel to the finger and the second round passed over it. It is continued in this manner with successive rounds applied above and below until the base of the finger is reached. At this point the final two rounds are on top of the free end. The bandage is then cut loose with the two ends tied in a square knot. This will give a snug fitting bandage with a minimum amount of material, with no adhesive used and no anchor to the wrist required.



Fig. 1. The first round of the bandage is applied above the free end.



Fig. 2. The second round of the bandage is applied on top of the free end.



Fig. 3. The free ends are tied in a square knot.

The only precaution is not to tie the knot too tightly. Usually the patient will inform you when the bandage is tight enough. It must be applied with care if there is marked swelling, but after a few trials one will soon become accustomed to applying it with the proper tension.

Keep the Home Fires Burning



President's Page

As we present the annual roster of the MICHIGAN STATE MEDICAL SOCIETY, it is significant to notice that to date 2,175 of our membership are in the armed forces of our country. This is a lion's share of Michigan doctors. It means that these doctors are making an extreme sacrifice. To give up homes and family, a practice which in many cases has taken years to build, and accept in the face of all this a decided reduction in income is truly a sacrifice. Still as Americans, these same doctors of medicine realize that all these sacrifices and hardships which they are encountering, to say nothing of the dangers to life and future health, are necessary to the safe future of our country and to provide the continuance of life, liberty and the pursuit of happiness for all of us.

Are we on the home front making sacrifices comparable to our fellow doctors in service? It is true we are working harder than ever to care for the citizens of our state and to continue to uphold the highest standards of health. We are continuing to carry on the programs of extramural and intramural courses in coöperation with the U. of M. and Wayne University. We are trying to keep the home fires burning in our county societies and our State Society so that when this world conflict is over and the 2,175 military members of our Society return home, we can greet them through their own county societies and extend a glorious welcome through their State Society.

We at home should pledge ourselves to see that every eligible doctor in the jurisdiction of our own county medical society becomes a member of the county society and the State Society.

Never before has that old saying, "In unity there is strength," been more necessary than now, if we are to defeat regimentation and preserve the practice of medicine for our doctors at war, as it was, or even better than it was, before they entered military service.

C. R. Keyport

President, Michigan State Medical Society.

EDITORIAL

WE NEED A BOOK

■ Not long ago one of our leading physicians asked the editor for references to a book that would give the status of the problem of socialized medicine, the arguments for and against regimentation and state medicine, and what can be done about it. He wished to study the subject in all its aspects, from both sides, and then to be able to formulate some conclusions for himself. Later the director of one of our industrial high schools asked for a list of information that could be set out for students who wish to work on this subject in their debates and other studies. Very recently the wife of one of our members who is serving as a Captain in the Army overseas, wrote to the Lansing office asking what, if anything, the medical profession is doing to counter the urge for regimentation. She said her husband had asked that she keep in touch and keep him informed. She was of the opinion that nothing is being done.

A few days ago the president of a great University, in an address to one of the Alumni groups, is reported to have said that the medical profession is the one great body that is doing nothing looking toward the betterment of services and conditions after the war; that "they are contributing nothing constructive, and are opposing all constructive proposals."

For years the schools have been conducting debates on the subject of better distribution of medical care, the regimentation of medicine, and state control. They have reference libraries giving the social side, the side of the dreamers, the side favoring government regimentation, but the picture from the standpoint of the medical profession and the private practitioner of medicine is lacking. Occasionally a few paragraphs, or a small pamphlet, dealing with some phase of the subject makes its appearance, but nothing eminently satisfactory.

The director of the high school has a just and logical question and should be aided in his quest for more and better information. The doctor has had this material confronting him in his every day life, in his contacts with government bureaus in the care of public charge cases, and in the medical journals. The doctor's wife is groping in the dark, not knowing where to find her material, and being disappointed.

But there is no excuse for the president of a great University, conducting one of the outstanding medical schools of the country, to be so woefully uninformed. The Michigan State Medical Society several years ago employed a university professor of economics to make a $20,000 study on this subject, searching for this very answer. Within the past five years it has invested another $17,000 to develop and establish a form of prepayment medical care. Michigan Medical Service is the most outstanding of many voluntary prepayment plans established and in operation throughout the United States.

The Michigan State Medical Society, in conjunction with the Michigan Department of Health, the Wayne University Medical School, and the University of Michigan Medical School, has made one of the most progressive and far-reaching experiments in bringing postgraduate medical studies to the private practitioner of medicine. In no place in the world has postgraduate medical study even matched what has been done in Michigan. Postgraduate medical study is certainly one of the necessary things needed to bring to the people the very best in medical care. The Michigan State Medical Society has also established a Foundation for the advancement of postgraduate medical study. This has all been accomplished by voluntary, not compulsory effort.

Plans for the postwar world of medicine, plans for the mental rehabilitation of our doctors in military service, plans for the preservation for our people of the individual and voluntary administration of medicine, the plan which is fundamentally and wholly American, have occupied the time and effort of our administrative bodies at and between every meeting for years. Many of us have advocated more intensive contacts with the public in the way of keeping them informed concerning what American medicine is, what it has done for the health and well-being of the country, and what the future may look for under

private enterprise, as well as under regimentation.

We need a book.

Someone must write a book to place this information in the reach of high school children who are asking for authentic knowledge. That book should tell what the practice of medicine is, the problems of education, the problems of distribution, the problems of research, the problems of coöperation, of consultation, of giving our people not just good medicine, but the very best that is known. That book would also be a good place to paint the picture of regimentation, of bureaucracy, of cultism.

Someone *must* write a book.

And that book should be placed gratis in every public library in the state, in every high school and college reading room in the state, in the hands of every teacher of social problems in the state, in the hands of the directing head of every educational institution in the state, and lastly in the hands of every doctor of medicine in the state.

Who will write this book?

How soon?

THE MICHIGAN HEALTH COUNCIL

■ The idea of forming a Michigan Health Council was advanced at a meeting on July 16 and 17, 1943, at Mackinac Island. This meeting was attended by the members of the Council of the Michigan State Medical Society and representatives of the Michigan Hospital Association, the Michigan Medical Service and the Michigan Hospital Service. There was unanimity at this meeting that a need existed for an organization which could act as a clearing house of all four organizations on matters of mutual interest. The Michigan Health Council is the result, and is being incorporated as a nonprofit organization, the object being to promote the health of the people by (a) coördinating the efforts of the four organizations and other groups interested in the health field in matters of common interest, (b) conducting a general educational program regarding the advantages to the health of the people to be gained through the private practice of medicine and related services and the operation of voluntary nonprofit hospitals, (c) taking all necessary and practical steps to arrange for the availability of medical, hospital and related services.

One of the first activities will be a survey of public opinion in Michigan to obtain the attitude of the public toward the medical profession, and hospitals, the cost of medical and hospital care, the attitude of the public regarding prepayment health plans under the auspices of professional groups, government, or other agencies, and other related matters. Pending the outcome of this survey, the Michigan Health Council will provide spokesmen who will address groups throughout the state, telling what is now being done by the medical profession and hospitals through private practice and the voluntary system to meet the needs of the people.

Tremendous progress has been made in medical science from the standpoint of care of the patient, research and education. In Michigan great progress has also been made from an economic standpoint through the development of the Michigan Medical Service and Michigan Hospital Service. More than one out of five persons in Michigan are now eligible for hospital service through the hospital plan, and more than one out of every nine persons are protected against the costs of surgical, obstetrical, anesthesia and x-ray services through the medical plan.

The medical profession and the hospitals, however, have been lax in keeping the public informed as to what is being done, and what is planned to be done to meet the needs of the people through private medical practice and the voluntary hospital system.

The Michigan Health Council will be an active force in the future for all our public contacts.

WAGNER-MURRAY-DINGELL BILL

■ There is increasing concern among public welfare administrators that the organized opposition to the controversial issues of compulsory health insurance and federalization of unemployment compensation may delay or kill consideration of the comparatively noncontroversial provisions for a unified public assistance program. A proposal has been made to explore the possibilities of a separate bill to incorporate the comparatively noncontroversial provisions of the Wagner-Murray-Dingell Bill under the assistance title. Medical economists have believed all along that there were parts of that bill which were of value and could be salvaged. This may point the way to a better understanding.

Michigan State Medical Society

Roster 1944

[An "M" following a name indicates active military service; "E" indicates Emeritus Members; "R" indicates Retired Members; all others are Active Members]

Allegan County

Beckett, M. B.....M
Brown, Lewis Freeman.....M
Brunson, Eugene T.....Ganges
Burdick, G. J.....Fennville
Dickinson, C. A.....Wayland
Dolfin, W. E.....M
Flinn, C. C.....Allegan
Hudnutt, Orinn Dean.....Plainwell
Johnson, E. B.....Allegan
Johnson, H. H.....Martin
Mahan, James E.....Allegan
Medill, W. C.....Plainwell
Ramsayer, Gladwin E.....Plainwell
Rigterink, George H.....Hamilton
Stuch, Howard T.....Allegan
Stuch, Olin H.....Otsego
TenPas, Henry W.....Hamilton
Van Ness, J. H.....Allegan
Vaughn, W. R.....Plainwell
Van Der Kolb, Bert.....Hopkins

Alpena-Alcona-Presque Isle Counties

Ahland, J. K.....Hastings
Bunting, John W.....Alpena
Burkholder, H. J.....Alpena
Carpenter, Clarence A.....Onaway
Constantine, Aeneas.....Harrisville
Foley, E. L.....Alpena
Hier, Edward A.....Alpena
Kessler, Harold.....M
Lightner, C. M.....Vallejo, Calif.
Nesbitt, Wm. E.....M
Newton, Wm. B.....Alpena
Ramsey, J. A.....M
O'Donnell, F. J.....Alpena
Parmenter, E. S.....Alpena
Purdy, John W.....Lachine
Rutledge, S. H.....M
Slade, H. G.....Rogers City
Trudeau, J. M.....M
Wienczewski, Theophile.....M

Barry County

Clarke, Daniel M.....Hastings
Finnie, R. G.....M
Fisher, Gordon F.....M
Gwinn, A. B.....Hastings
Harkness, Robt. B.....Hastings
Keller, Guy C.....Hastings
Lathrop, Clarence P.....Hastings
Lofdahl, Stewart.....Nashville
Lund, Chester A. E.....Middleville
McIntyre, K. S.....M
Morris, Edgar T.....Nashville
Wedel, Herbert S.....Hastings

Bay-Arenac-Gladwin-Iosco Counties

Alcorn, Kent.....Bay City
Allen, A. D.....Bay City
Asline, J. N.....M
Austin, Justis.....Tawas City
Baker, Chas. H. ....(E) Bay City
Ballard, Sylvester L.....Bay City
Ballard, W. R.....Bay City
Boulton, Arthur O....(E)..Gladwin
Brown, G. M.....Bay City
Connelly, C. J.....M
Criswell, R. H.....Bay City
Dardas, M. J.....M
DeWaele, Paul L.....M
Drummond, Fred.....Kawkawlin
Dumond, V. H.....Bay City
Foster, L. F.....Bay City
Freel, John A.....Bay City
Gamble, W. G., Jr.....Bay City
Gronemeyer, W. H.....M
Groomes, Charles.....Bay City
Grosjean, J. C.....Bay City
Gunn, Robert.....Detroit
Hall, R. F.....M
Hagelshaw, G. L.....M
Hasty, Earl.....Whittemore
Hess, C. L.....Bay City
Heuser, Harold H.....Bay City
Horowitz, S. Franklin.....M
Huckins, E. S.....Bay City
Hughes, E. C.....Bay City
Husted, F. Pitkin.....M
Jacoby, A. H.....M
Jens, Otto.....Essexville
Jones, Jerry M.....Bay City
Keho, John.....Bay City
Kerr, Wm.....Bay City
Kessler, Mana.....Bay City
Kessler, S.....Bay City
Knobloch, Howard.....M
Lane, Milton.....M
Lerner, David.....M
McDonnell, Walter R.....M
McEwan, J. H.....Bay City
MacPhail, Joseph.....M
Medvesky, M. J.....M
Miller, Edwin C.....M
Mitton, Orland W.....East Tawas
Moore, George W.....Bay City
Moore, Neal R.....M
Mosier, D. J.....M
Pearson, Stanley M.....M
Perkins, Roy C.....Bay City
Ruetter, C. W.....M
Riley, R. B.....M
Scrafford, Royston Earl.....Bay City
Shafer, H. C.....M
Sherman, R. N.....Bay City
Siler, Delbert.....Bay City
Slattery, M. R.....Bay City
Smith, William Marshall...Bay City
Staley, Hugh.....B.....Omer
Stewart, G. C.....c/o Allen Clinic, Bay City
Stinson, W. S.....Bay City
Stuart, Alexander A.....Bay City
Stuart, Kenneth.....Bay City
Swantek, Charles M..(R)..Bay City
Switzer, W. W..c/o Chevrolet Motor Co., Bay City
Tarter, Clyde S.....M
Timreck, Harold A.....M
Tupper, V. L.....Bay City
Urmston, Paul R.....Bay City
Warren, E. C.....Bay City
Wilcox, J. W.....Bay City
Wilson, Thomas G.....Bay City
Wittwer, E. A.....Bay City
Wood, Neal....City Hall, Bay City
Woodburne, H. L.....M
Zaremba, Aloysius J.....Bay City
Ziliak, A. L.....Bay City

Berrien County

Allen, Robt. Clarke.....St. Joseph
Anderson, Bertha.....St. Joseph
Bartlett, W. M.....M
Belsley, Frank K....Benton Harbor
Brown, F. W.....Watervliet
Brown, G. W.....Buchanan
Brown, Rolland J.....M
Burrell, H. J.....Benton Harbor
Cawthorne, H.J.....Benton Harbor
Conybeare, R. C.....Benton Harbor
Crowell, Richard.....M
Dunnington, R. N....Benton Harbor
Eidson, D.....Berrien Springs
Ellet, W. C.....M
Faber, Michael.....Benton Harbor
Fredrickson, H. C.....Buchanan
Friedman, M. E.....New Buffalo
Gillette, Clarence H.....Niles
Hanna, P. G.....St. Joseph
Harper, Ina.....Benton Harbor
Harrison, L. L.....Niles
Hart, Russell T.....Niles
Henderson, Fred.....Niles
Henderson, Robert.....Niles
Herring, N. A.....Niles
Hershey, Noel J.....M
Huff, H. D.....Niles
King, Frank, Jr.....M
Kling, H. C.....Niles
Leva, John B.....M
McDermott, J. J.....St. Joseph
Merritt, Charles W.....St. Joseph
Miller, E. A.....Berrien Springs
Mitchell, Carl A.....Benton Harbor
Moore, T. Scott.....Niles
Ozerman, Chas. J.....Benton Harbor
Reagan, Robt.....M
Rein, Gerald.....Benton Harbor
Richmond, D. M.....St. Joseph
Rosenberry, A. A....Benton Harbor
Ruth, J. G.....M
Smith, W. A. .....Berrien Springs
Sowers, Bouton.....M
Strayer, J. C.....M
Thorup, Don W.....Benton Harbor
Westervelt, H. O.....Benton Harbor
Yeomans, T. G.....St. Joseph

Branch County

Andrews, Frank A.....Coldwater
Bailey, J. E.....Coldwater
Beck, Perry C.....Bronston
Brunson, A. E.....Colon
Bien, W. J.....Coldwater
Chipman, E. M.....M
Culver, Bert W.....Coldwater
Far, S. E.....Quincy
Fraser, R. J.....M
Joerin, Wm. A.....M
McLain, R. W.....Jackson
Meier, H. J.....M
Mooi, H. R.....Union City
Olmstead, Kenneth L.....M
Phillips, F. L.....Bronson
Rees, K. B.....Coldwater
Schultz, Samuel.....Coldwater
Scovill, H. A.....M
Smith, L. Lloyd.....M
Thomas, J. A.....Coldwater
Wade, R. L.....Coldwater
Walton, N. J.....Quincy
Weidner, H. R.....M

Calhoun County

Amos, Norman H.....M
Baribeau, R. H.....Battle Creek
Barnhart, Samuel H....Battle Creek
Becker, H. F.....M
Beuker, Herman.....Marshall
Bonifer, Phillip.....M
Braham, Wilbur.....M
Brainard, C. W.....M
Campbell, Alice.....Albion
Campbell, R. J.....M
Capron, Manley J.....M
Church, Starr K.....(E)..Marshall
Chynoweth, W. R.....M
Cooper, J. E.....Battle Creek
Curless, Grant R.....M
Curry, Robt. K.....M
Dickson, A. R.....Battle Creek
Dodge, Warren M., Jr.....M
Fairbanks, Stephen.....Albion
Finch, D. L.....Battle Creek
Forsyth, J. F.....M
Frank, David L.....M
Fraser, R. H.....Battle Creek
Funk, L. D.....Athens
Gething, Joseph W.....Battle Creek
Giddings, A.....Battle Creek
Gilfillan, Margery J.....Battle Creek
Graubner, F. L.....M
Hafford, A. T.....Albion
★Hale, C. E.....
Hansen, E. L.....Battle Creek
Hansen, Harvey C.....M
Harris, R. H.....Battle Creek
Haughey, Wilfrid.....Battle Creek
Heald, C. W.....Battle Creek
Henderson, Louis N.....Albion
Henderson, Philip M.....Albion
Herzer, Henry A.....Albion
Hills, C. R.....Battle Creek
Holes, Jesse J.....Battle Creek
Holtom, B. G.....Battle Creek
Howard, W. L.....Battle Creek
Hoyt, Aura A.....Battle Creek
Hubly, James W.....M
Humphrey, Arthur A.....M
Humphrey, A. Edward.....Marshall
Jesperson, Lydia.....Battle Creek
Jones, T. K.....M
Keagle, Leland R.....M
Keeler, K. B.....Albion
Kingsley, Paul C.....M
Kinde, M. R.....M
Kolvoord, Theodore.....Battle Creek
LaPorte, L. A.....Battle Creek
Levy, Joseph.....M
Lewis, W. B.....Battle Creek
Lowe, H. M.....Battle Creek
Lowe, Kenneth.....M
Lowe, Stanley T.....M
MacGregor, Archibald E.
Battle Creek
Manni, Lawrence C.....Battle Creek
McNair, L. N.....Albion
Meister, F. O.....M
Melges, F. J.....Battle Creek
Mercer, C. M.....Battle Creek
Morrison, Donald B.....M
Mullenmeister, H. F.....M
Mustard, Russell.....Battle Creek
Norman, Estelle G.....Battle Creek
Norton, Richard C.....M
Patterson, Adonis.....M
Putman, W. N.....Battle Creek
Radabaugh, Clara V....Battle Creek
Robbert, John.....Battle Creek
Robins, Hugh.....Marshall
Rorick, Wilma Weeks..Battle Creek
Rosenfeld, J. E.....Battle Creek
Royer, C. W.....M
Schelm, George W.....Battle Creek
Selmon, Bertha L.....Battle Creek
Sharp, A. D.....Albion
Shipp, L. P.....Battle Creek
Sibilsky, A. Clark.....Battle Creek
Simpson, R.....M
Slagle, George W.....M
Sleight, James D.....M
Smith, T. C.....M
Stadle, Wendell H.....M
Stiefel, Richard.....Battle Creek
Tannenholz, Harold S..Battle Creek
Taylor, Clifford B.....M
Toms, Roland E.....M
Upson, W. O.....Battle Creek
Van Camp, Elijah.....Battle Creek
Verity, Lloyd E.....Battle Creek
Vollmer, Maud J. O.....Moline, Ill.
Walters, F. R.....Battle Creek
Walters, Royal W.....Battle Creek
Watson, Bernard.....M
Winslow, Rollin C.....Battle Creek
Winslow, Sherwood B...Battle Creek
Zindler, George A.....Battle Creek
Zinn, Karl.....M

Cass County

Adams, U. M.....Marcellus
Clary, R. I.....M
Hickman, John K.....M
Kelsey, Jas. H.....Cassopolis
Loupee, George.....Dowagiac
Loupee, S. L.....Dowagiac
Lyman, W. R.....Dowagiac
Myers, Charles M.....Dowagiac
Pierce, Kenneth C.....Dowagiac
Rice, Franklin.....M
Swengel, D. H.....Cassopolis

Chippewa-Mackinac Counties

Birch, Wm.....M
Blair, H. M.....M
Carr, E. S.....Pickford
Conrad, George A...Sault Ste. Marie
Cornell, Eliphalet A.....
(E)..Sault Ste. Marie
Cowan, Donald.....M
Darby, J. F.....St. Ignace
Gilfillan, E. O.....Clear Lake, Iowa
Hagele, Marie A...Sault Ste. Marie
Hakala, L. J.....M
Harrington, H. M...Sault Ste. Marie
McBryde, Lyman M.....
Sault Ste. Marie
MacDonald, A.....Mackinaw Island
Mertaugh, W. F.....M
Maloney, F. J.....Sault Ste. Marie
Montgomery, B. T..Sault Ste. Marie
Rhind, E. S.....Sault Ste. Marie
Vegors, Stanley H..Sault Ste. Marie
Wallen, LeRoy J.....M
Webster, E. H.....Sault Ste. Marie
Willison, C.....Sault Ste. Marie
Wood, Neal N.....Charlevoix
Yale, I. V.....Sault Ste. Marie

Clinton County

Bennett, George W.....Elsie
Cook, Bruno.....Westphalia
Elliott, Bruce R.....Ovid
Foo, Chas. T.....St. Johns
Frace, Guy E.....St. Johns
Hart, Dean W.....M
Henthorn, A. C.....St. Johns
Ho, Thomas Y.....St. Johns
Luton, F. E.....St. Johns
McWilliams, W. B.....Maple Rapids
Russell, Sherwood.....M
Stoller, Paul F.....Fowler
Wahl, George Edward.....M

Delta-Schoolcraft Counties

Benson, G. W.....Escanaba
Boyce, D. H.....Escanaba
Brenner, Ervin J.....M
Carlton, A. J.....Escanaba
Chenowyth, Nancy R.....Escanaba
Clausen, Claire H.....M
Diamond, J. A.....Gladstone
Frenn, Nathan J.....Bark River
Fyvie, James.....M
Groos, Harold Q.....Escanaba
Groos, Louis P.....Escanaba
Kitchen, A. S.....Escanaba
Lemire, Wm. A.....M
Lindquist, N. L.....Manistique
Long, Harry W.....Escanaba
McInerney, Edna C.....Escanaba
McInerney, Thomas A.....M
Miller, Albert H.....Gladstone
Mitchell, James D.....Gladstone
Moll, G. W.....Escanaba
Shaw, George A.....Manistique
Walch, J. J.....Escanaba

★Died in Military Service

Dickinson-Iron Counties

Addison, E. R.....Crystal Falls
Alexander, W. H.....Iron Mountain
Andersen, E. B.....Iron Mountain
Boyce, Geo. H.....Iron Mountain
Browning, James L.....M
DeSalvo, F.....Niagara, Wis.
Fiedling, Wm.....Norway
Fredrickson, Geron...Iron Mountain
Gloss, Kenneth E.....M
Haight, H. H.....M
Hayes, R. E.....Sagola
Huron, W. H.....Iron Mountain
Irvine, L. E.....Iron River
Kofmehl, Wm. J.....Stambaugh
McEachran, Hugh D.....M
Menzies, Clifford.....Iron Mountain
Retallack, R. C....N. Uvalde, Texas
Smith, Donald R.....Iron Mountain
White, Robert E.....Stambaugh
Witkow, Alexander...Iron Mountain

Eaton County

Arner, Fred L.....Bellevue
Brown, B. P.....M
Burdick, Austin F.....Grand Lake
Carothers, Daniel J.....M
Clements, F. W.....Eaton Rapids
Engle, Paul.....Olivet
Goff, S. B.....M
Hannah, H. W.....Charlotte
Hargrave, Don V.....Eaton Rapids
Huber, Chas. D.....Charlotte
Huyke, Stanhope Pier.....M
Imthum, Edgar F.....M
McLaughlin, C. L. D...Vermontville
Myers, Albert W.....Potterville
Paine, E. Madison, Jr.....M
Quick, Phil H.....Olivet
Rickerd, Vinton J.....Charlotte
Sackett, C. S.....(R)..Charlotte
Sassaman, F. W.....Charlotte
Sevener, C. J.....Charlotte
Sevener, Lester G.....Charlotte
Stucky, George.....Charlotte
Van Ark, Bert.....M

Genesee County

Adams, Chester.....M
Andrews, N. A.....M
Anthony, George E.....M
Backus, Glenn R.....M
Baird, James.....Flint
Bald, Frederick W.....M
Barbour, Fleming A.....M
Baske, Franklin W.....Flint
Bateman, L. G.....M
Benson, J. G.....Flint
Bernstein, Eli N.....M
Biggar, H. R.....Flint
Bishop, D. L.....Flint
Blakeley, A. C.....Flint
Bogart, Leon M.....Flint
Boles, Wm. P.....Flint
Bonathan, A. T.....Flint
Bradley, Robt.....M
Brain, R. Gordon.....Flint
Branch, Hira E.....M
Brasie, D. R.....Flint
Briggs, Guy D.....Flint
Bruce, Wm. W.....M
Buchanan, W. Fremont.....M
Burkett. L. V.....Flint
Burnell, Max.....Flint
Burnside, Howard B.....M
Chaffee, Elsa.....Flint
Chambers, Myrton S.....Flint
Chandler, M. E.....Flint
Charters, John H.....Flint
Childs, Lloyd H.....Flint
Clark, Clifford P.....Flint
Colwell, C. W.....M
Connell, J. T.....Flint
Conover, G. V.....M
Conover, T. S.....Flint
Cook, Henry.....Flint
Covert, F. L.....Gaines
Credille, B. A.....Flint
Curry, George.....Flint
Curtin, J. H.....Flint
Del Zingro, N.....Davison
Dimond, E. G.....Flint
Dodds, F. E.....Flint
Drewyer, Glen.....M
Edgerton, A. C.....Clio
Eichhhorn, Ernest.....Flint
Eickhorst, Thomas N.....M
Elliott, H. B.....Flint
Ettinger, Ralph D.....Clio
Farhat, M. M.....M
Finkelstein, T.....M
Flynn, S. T.....M
Foley, S. I.....Flint
Fuller, Hugh T.....M
Gelenger, S. M.....M
Gleason, N. A.....Flint
Goering, George R.....Flint
Golden, Evelyn Cohen.....Flint
Golden, H. Maxwell.....Flint
Goodfellow, B. J.....Flint
Gorne, S. S.....M
Gray, Edwin F.....M
Grover, H. F.....Flint
Guile, Earle.....Flint
Guile, G. S.....Flint
Gundry, G. L.....Grand Blanc
Gutow, J. J.....M
Hague, R. F.....M
Halligan, Raymond S.....Flint
Hamady, Ruth.....Flint
Handy, John W.....(E)..Flint
Harper, A. W.....Flint
Harper, Homer.....Flint
Harrison, Leo D.....Flint
Hawkins, James E.....Flint
Haymond, Josseph L.....Flint
Hays, George A.....M
Hiscock, H. H.....M
Houston, James.....Swartz Creek
Hubbard, Wm. B.....Flint
Hufton, Wilfred L.....Flint
Jefferson, Harry.....Flint
Johnson, Arthur H.....Flint
Johnson, Frank D.....M
Jones, Lafon.....Flint
Kaleta, Edward.....M
Kaufman, Lewis D.....M
Kirk, A. Dale.....Flint
Knapp, M. S.....(R)..Fenton
Kretchmar, A. H.....Flint
Kurtz, J. J.....Flint
Lambert, L. A.....M
Lavin, Kathryn R.....Flint
Leach, J. L.....Flint
Livesay, Jackson E.....Flint
Logan, G. W.....Flushing
MacDuff, R. B.....Flint
MacGregor, D. M.....Flint
MacGregor, R. W.....Flint
Macksood, Joseph.....Flint
Marsh, H.....Flint
Marshall, Wm. H.....Flint
Mason, Elta.....Flint
Matthewson, Guy C.....Flint
McArthur, A.....Flint
McArthur, R. H.....M
McGarry, R. A.....Flint
Miller, Bryce.....Flushing
Miller, Edwin E.....Flint
Miller, Loren E.....M
Miltick, Anthony J.....Flint
Miner, Frederick B.....Flint
Moore, J. W.....Flint
Moore, Kenneth B.....Flint
Morrish, Ray S.....Flint
Morrissey, V. H.....Flint
Mosier, Edward C.....Otisville
Odle, Ira.....Flint
Olson, James.....Flint
O'Neil, C. H.....(R)..Deckerville
Orr, J. Walter.....Flint
Patterson, A. A.....Flint
Phillips, R. L.....Flint
Pfeifer, A. C.....Mt. Morris
Pratz, O. C.....Flint
Preston, Otto.....Flint
Probert, C. C.....Flint
Randell, H. E.....Flint
Reeder, Frank E.....Flint
Reichard, Orill.....Flint
Reid, Wells C.....Goodrich
Richeson, V.....Flint
Rieth, George F.....M
Reynold, A. J.....Flint
Roberts, Floyd A.....Flint
Rowley, James A.....Flint
Rummell, Robert J.....Grand Ledge
Rundles, Walter Z.....M
Rynearson, W. J.....Fenton
Sandy, K. R.....M
Scavarda, Charles J.....M
Schiff, B. A.....M
Scott, R. D.....Flint
Shantz, L. O.....Flint
Sleeman, Blythe R.....Linden
Sheeran, Daniel H.....Flint
Shipman, Charles W.....Flint
Smith, D. C.....Flint
Smith, E. C.....Flint
Smith, Maurice J.....M
Sniderman, Benj.....M
Snyder, Charles E.....M
Sorkin, Morris L.....M
Sorkin, S. S.....M
Steinman, F. H.....M
Stevenson, W. W.....Flint
Streat, R. W.....Flint
Stroup, C. K.....Flint
Sutherland, Jas. K.....Flint
Sutton, M. R.....Flint
Thompson, Alvin.....Flint
Thomson, J. Oscar.....Grand Blanc
Tofteland, Elmer H.....M
Trumble, G. W.....Flint
Van Gorder, Geo.....M
Vary, Edwin P.....M
Walcott, C. G.....M
Ward, Nell.....Flint
Ware, Frank.....Flint
Wark, D. R.....Flint
Werness, Inga W.....Flint
White, Carl H.....M
White, Herbert.....Flint
Williams, W. S.....Flint
Willoughby, G. L.....M
Willoughby, L. L.....Flint
Wills, T. N.....Flint
Wilson, Wm. K.....M
Woughter, Harold W.....M
Wright, D. R.....Flint
Wright, G. R.....Montrose
Wyman, J. S.....Flint

Gogebic County

Anderson, C. E.....Anvil
Gertz, M. A.....Ironwood
Gorrilla, A. C.....Ironwood
Hendrickson, A. O.....Ironwood
Lieberthal, M. J.....Ironwood
Lieberthal, P. R.....Ironwood
Nezworski, H. T.....Ironwood
Pierpont, D. C.....Ironwood
★Reid, J. D.....
Reynolds, F. L. S.....Ironwood
Stevens, C. E.....Ironwood
Tew, W. E.....Bessemer
Tressel, H. A.....Wakefield
Urquhart, C. C.....Ironwood
Wacek, W. H.....Ironwood

★Died in military service

Grand Traverse-Leelanau-Benzie Counties

Baumann, Milton C.....M
Boland, Ellis J.....Suttons Bay
Brownson, Jay J.....Kingsley
Brownson, Kneale.....M
Bushong, B. B.....Traverse City
Covey, E. L.....Honor
Ellis, Claude I.....Suttons Bay
Gauntlett, J. W.....Traverse City
Goodrich, Dwight.....Traverse City
Grawn, F. A.....Traverse City
Hamilton, Earl E.....M
Huene, Nevin.....M
Huston, Russell R.....Elk Rapids
Hyslop, Wm. T.....Traverse City
Jerome, Jerome T.....Traverse City
Kitson, V. H.....Elk Rapids
Knapp, Jos. L.....M
Kyselka, H. B.....Traverse City
Lemen, Chas. E.....M
Lentz, R. J.....M
Lossman, R. T.....Traverse City
Murphy, Fred E.....Traverse City
Nickels, M. M.....M
Osterlin, Mark.....Traverse City
Sheets, R. Philip.....Traverse City
Sladek, E. F.....Traverse City
Stone, Fordyce H.....Beulah
Swanton, L.....Traverse City
Swartz, F. G.....Traverse City
Thacker, Fred R.....Frankfort
Thirlby, E. L.....Traverse City
Thompson, T. W.....Traverse City
Trautman, Frederick B.....M
Way, Lewis R.....M
Weitz, Harry.....Traverse City
Wilcox, Paul H.....Traverse City
Willard, Wm. G.....Benzonia
Willoughby, Frances L.....M
Zielke, I. H.....M
Zimmerman, J. G.....Traverse City

Gratiot-Isabella-Clare Counties

Aldrich, Alfred L.....Ithaca
Barstow, D. K.....M
Barstow, W. E.....St. Louis
Baskerville, C. M.....Mt. Pleasant
Becker, M. G.....Edmore
Budge, M. J.....Ithaca
Burch, L. J.....Mt. Pleasant
Burt, C. E.....Ithaca
Carney, T. J.....Alma
Dale, Edward C.....M
Davis, L. L.....M
Drake, Wilkie M.....Breckenridge
Du Bois, C. F.....Alma
Graham, B. J.....M
Hall, B. C.....Pompeii
Hammerberg, Kuno.....M
Harrigan, W. L.....Mt. Pleasant
Hersee, Wm. E.....M
Hobbs, A. D.....St. Louis
Hodge, C. L.....Reading
Hyslop, Leland F.....Mt. Pleasant
Johnson, P. R.....Mt. Pleasant
Kilborn, H. F.....Ithaca
Kline, Fred.....Litchfield
Lamb, E. T.....Alma
McArthur, Stewart C.....Clare
Miller, S. W.....M
Oldham, E. S.....M
Poppen, C. J.....Reading
Putzig, Louis M.....Blanchard
Rondot, E. F.....Lake
Rottschafer, J. L.....M
Sharon, J. P.....Mt. Pleasant
Silvert, P. P.....Vestaburg
Slattery, F. G.....M
Strange, Russell H.....Mt. Pleasant
Waggoner, R. L.....St. Louis
Wilcox, R. A.....Alma
Wilson, Earl C.....Harrison
Wolfe, Kenneth P.....Alma
Wood, Cornelius B.....M

Hillsdale County

Alleger, W. E.....Pittsford
Bower, Chas. T.....Hillsdale
Clobridge, C. E.....Allen
Davis, L. A.....Montgomery
Day, Luther W.....Jonesville
Douglas, E. W.....Hillsdale
Fisk, Fred B.....Jonesville
Green, B. F.....Hillsdale
Hamilton, A. J.....Hillsdale
Hanke, George R.....Ransom
Hughes, Henry F.....Cambria
Johnson, C. E.....M
Kinzel, R. W.....M
MacNeal, John A.....Hillsdale
Martindale, E. A.....Hillsdale
Mattson, H. F.....M
McFarland, O. G.....North Adams
Miller, Harry C...San Diego, Calif.
Moench, G. F.....Hillsdale
Sandor, A. A.....M
Sawyer, Walter W.....M
Sterling, John S.....Jerome
Strom, A. W.....M

Houghton-Baraga-Keewenaw Counties

Abrams, James C.....Calumet
Acocks, J. R.....M
Aldrich, A. B.....Houghton
Aldrich, Addison D.....Houghton
Aldrich, Leonard.....M
Bourland, Philip D.....Calumet
Brewington, G. F.....Mohawk
Buckland, R. S.....Baraga
Burke, John.....Hubbell
Coffin, Leslie E.....Painesdale
Cooper, A. C.....Hancock
Gregg, W. T. S.....Calumet
Hilmer, R. E.....Beacon Hill
Janis, A. J.....Hancock
Kadin, Maurice.....M
King, Wm. T.....Ahmeek
Kirton, Joseph R. W.....Calumet
Kolb, F. E.....M
LaBine, Alfred.....Houghton
Levin, Simon.....Houghton
MacQueen, Donald K..(E)..Larium
Manthei, W. A.....Lake Linden
Marshall, Frank F.....L'Anse
McClure, R. J.....Calumet
Pleune, R. E.....M
Quick, James B.....Larium
Roche, A. C.....Calumet
Roche, A. M.....M
Sarvela, H. L.....Hancock
Sloan, P. S.....Houghton
Smith, Charles R.....Houghton
Stern, I. D.....Houghton
Tinetti, Ernest F.....M
Ware, H. M.....Nahma
Wickliffe, T. P.....Calumet
Wilson, P. H.....Chassell
Winkler, Henry J.....L'Anse

Huron County

Gettle, Roy R.....Kinde
Henderson, J. Bates.....Sebewaing
Herrington, Charles I.....Bad Axe
Herrington, Willet J.....Bad Axe
Holdship, Wm. B.....Ubly
Monroe, Duncan J.....Elkton
Morden, Charles B.....Bad Axe
Oakes, C. W.....Harbor Beach
Ritsema, John.....Sebewaing
Scheurer, C.....Pigeon
Thumme, Harrison F.....Sebewaing

Ingham County

Albert, Wilford D.....Leslie
Andrews, F. T.....Lansing
Atkinson, Everett H.....E. Lansing
Barrett, C. D.....Mason
Bartholomew, Henry S..(R).Lansing
Bauer, Theodore I.....Lansing
Behen, Wm. C.....Lansing
Bellinger, E. G.....Lansing
Black, Chas. E.....Williamston
Black, Gertrude.....Williamston
Block N. Bernita....Juneau, Alaska
Bobczynski, W. E.....Lansing
Bradford, C. W.....Lansing
Breakey, Robt S.....Lansing
Brown, F. W.....M
Brubaker, E.....Lansing
Brucker, Karl B.....Lansing
Bruegel, O. H.....E. Lansing
Burhans, R. A.....M
Calomeni, A. D.....Lansing
Cameron, W. J.....Lansing
Carr, E. I.....Lansing
Chapman, W.....Lansing
Christian, L. G.....Lansing
Clark, Wm. E.....M
Clinton, George.....M
Cook, Martin J.....M
Cook, R. J.....Lansing
Cope, H. E.....Lansing
Corneliuson, Goldie B.....Lansing
Corsaut, J. C.....Mason
Cross, Frank S.....Lansing
Darling, L. G.....Lansing
Dart, Dorothy O.....Lansing
Davenport, C. S.....Lansing
Dean, Carleton.....Lansing
Delay, C. P.....Webberville
Devries, C. F.....Lansing
Dolbee, Malcolm.....E. Lansing
Doyle, Charles R.....M
Doyle, C. P.....Lansing
Drolett, Donald J.....M
Drolett, Fred C.....Lansing
Drolett, Lawrence.....M
Dunn, F. C.....Lansing
Dunn, F. M.....Lansing
Ellis, Bertha.....Lansing
Ellis, C. W.....Lansing
Feeney, Kenneth J.....Lansing
Finch, Russell L.....Lansing
Fisher, D. W.....M
Folkers, Leonard M.....E. Lansing
Fosget, Wilbur W.....Lansing
Foust, E. H.....Lansing
French, Horace L.....Lansing
Fryer, D. H.....Lansing
Galbraith, Dugald A.....Lansing
Gardner, C. B.....Lansing
Gibson, T. E.....M
Goldner, R. E.....M
Gunderson, G. O.....Lansing
Heald, Gordon.....M
Harris, Dean W.....Lansing
Harris, H. W.....M
Harrold, J. F.....M
Hart, L. C.....Lansing
Haynes, Howard B.....Lansing
Haze, H. A.....Lansing
Heckert, Frank B.....Lansing
Heckert, J. K.....Lansing
Hendren, Owen.....M
Henry, L.....Lansing
Hermes, E. J.....Lansing
Himmelberger, R. J.....M
Hodges, Kenneth P.....M
Holland, Chas. F.....E. Lansing
Huggett, Clare C.....Lansing
Hughes, H. A.....M
Huntley, Fred M.....Lansing
Hurth, M. S.....M
Johnson, K. H.....M

Jones, Francis A.....Lansing
Jones, Francis A. Jr.,.....Lansing
Kalmbach, R. E.....Lansing
Keim, C.....Lansing
Kelly, Wm. H.....M
Kent, Edith Hall.....Lansing
Kent, Herbert K.....Lansing
Kielhorn, W. P.....M
Koppa, T. M.....Lansing
Kraft, L. C.....Leslie
Kramer, S. D.....Lansing
Lang, R. R.....Lansing
Larabee, E. E.....Williamston
LeDuc, Don M.....M
Ley, Wilfred.....M
Loree, Maurice C.....Lansing
Lucas, T. A.....Lansing
Ludlum, L. C.....Lansing
Markuson, Kenneth E....E. Lansing
Martin, Wayne.....Lansing
McConnell, E. G.....(R)..Lansing
McCorvie, C. Ray.....E. Lansing
McCoy, Earl M.....Grand Ledge
McCrumb, R. R.....Lansing
McElmurry, Leland R.....Lansing
McElmurry, N. K.....Perry
McGillicuddy, Oliver B.....M
McGillicuddy, R. J.....M
McIntyre, J. Earl.....Lansing
McNamara, B. E.....M
McNamara, Wm. E.....Lansing
McPherson, E. G.....Mt. Clemens
Meade, Wm. H.....M
Mercer, Walter E.....M
Meyer, H. R.....Lansing
Miller, H. A.....Lansing
Mitchell, A. B.....Lansing
Molner, Stephen K.....Lansing
Morrison, C. V.....Lansing
Morrow R.....M
Niles, B. D.....Lansing
O'Sullivan, Gertrude.....Mason
Phillips, R. H.....Lansing
Pinkham, R. A.....Lansing
Ponton, J.....Mason
Potter, Earl C.....M
Prall, H. J.....Lansing
Randall, O. M.....Lansing
Rector, Frank L.....Lansing
Richards, F. D.....M
Richardson, M. L.....Lansing
Roberts, D. W.....Okemos
Roberts, Russell R.....Lansing
Robson, Edmund J.....M
Rozan, J. S.....Lansing
Rozan, M. M.....M
Russell, Claude V...(R)..Northport
Sander, John F.....M
Sanford, Thomas M.....Lansing
Seger, Fred L.....Lansing
Shaw, Milton.....Lansing
Shepherd, Clara S.....Lansing
Sherman, G. A.....E. Lansing
Sichler, Harper G.....E. Lansing
Silverman, Irving E.....M
Smith, Anthony V.....Mason
Smith, Lillian R.....Lansing
Smith, H. M.....Lansing
Snell, D. M.....Lansing
Snyder, LeMoyne M.....Lansing
Spencer, Perry.....M
Stanka, A. G.....Charlotte
Steiner, A. A.....M
Stiles, Frank.....M
Strauss, P. C.....Lansing
Stringer, C. J.....Lansing
★Sullivan, Ralph .....
Swartz, Frederick C.....M
Tallman, Frank F.....Lansing
Tamblyn, F. W.....M
Thiehoff, E. V.....Lansing
Thomas, Lucius G.....M
Toothaker, Kenneth.....M
Town, F. R.....Lansing
Towne, Lawrence C.....Lansing
Trescott, R. F.....M
Troost, F. L.....Holt
Vander Slice, E. R.....Lansing
Vander Zalm, T. P.....M
Venier, J. H.....E. Lansing
Wadley, Ralph.....Lansing
Warford, J. T.....Lansing
Webb, Roy O.....M
Weber, Francis J.....Lansing
Weinburgh, H. B.....Lansing
Welch, Wm. H.....E. Lansing
Wellman, John.....M
Wetzel, John O.....Lansing
Wilensky, Thomas.....Lansing
Wiley, Harold W.....Lansing
Willson, Howard S.....Lansing
Wilson, Harry A.....Lansing

Ionia-Montcalm Counties

Benison, Arthur L.....M
Botting, A. E.....Portland
Bird, Wm. L.....Greenville
Bower, A. J.....Greenville
Bracey, L. E.....Sheridan
Bunce, E. P.....Trufant
Bunce, Leo.....Trufant
Cook, Geo. H.....Ionia
Dunkin, Lloyd S.....M
Ferguson, F. H.....Carson City
Fleming, J. C.....Pewamo
Fox, Harold M.....Portland
Geib, O. P.....Carson City
Hansen, Carl M.....M
Hansen, M. M.....Greenville
Haskell, Robert H.....Northville
Hay, John R.....Saranac
Hoffs, M. A.....Lake Odessa
Imus, H. L.....Ionia
Johns, Joseph.....Ionia
Kelsey, L. E.....Lakeview
Kling, V. F.....M
Lilly, Issac S.....Stanton
Lintner, Roy C.....Ludington
Marsh, F. M.....Ionia
Marston, L. L.....Lakeview
McCann, John J.....Ionia
Mintz, Morris J.....M
Norris, Wm. W.....Portland
Peabody, C. H.....Lake Odessa
Phelps, Everett L.....M
Robertson, P. C.....Ionia
Seidel, Karl E.....M
Slagh, Milton E.....M
Socha, Edmund S.....Ionia
Swift, E. R.....Lakeview
VanDusen, V. L.....Grand Rapids
VanLoo, J. A.....M
Whitten, R. R.....Ionia
Willits, C. O.....Saranac

Jackson County

Ahronheim, J. H.....M
Alter, R. H.....Jackson
Anderson, W. B.....Jackson
Appel, S.....M
Baker, G. M.....Parma
Balconi, Henry.....Jackson
Bartholic, F. W.....M
Beckwith, S. A.....Stockbridge
Bullen, C. R.....Jackson
Chabut, H. M.....Jackson
Chivers, R. W.....Jackson
Clarke, C. S.....Jackson
Cochrane, Wayne A.....Jackson
Cooley, Randall M.....Jackson
Corley, C.....Jackson
Corley, Ennis.....Jackson
Cox, Ferdinand.....Jackson
Crowley, Edward D.....M
Culver, Guy D.....Stockbridge
DeMay, C. E.....Jackson
Dengler, C. R.....Jackson
Edmonds, J. M.....M
Enders, W. H.....Jackson
Filip, H. K.....Jackson
Finton, Walter L.....Jackson
Finton, W. R.....M
Foust, W. L.....Grass Lake
Gibson, F. J.....Jackson
Glover, H. G.....(R)..Jackson
Gordon, D. L.....M
Greenbaum, Harry.....M
Habenicht, Hilda.....Jackson
Hackett, T. E.....Jackson
Hanft, Cyril F.....Springport
Hanna, R. J.....M
Hardie, G. C.....Jackson
Harris, Lester J.....Jackson
Hicks, Glenn C.....Jackson
Holst, John B.....M
Huntley, W. B.....Jackson
Hurley, H. L.....Jackson
Keefer, A. H.....Concord
Kudner, Don F.....Jackson
Lake, Wm. H.....Jackson
LaVictore, Isaac N.....M
Leahy, E.....Jackson
Lenz, C. R.....M
Leonard, Clyde A.....Jackson
Lewis, E. F.....Jackson
Lejacono, Salvatore.....Jackson
Ludwick, J. E.....M
McGarvey, W. E.....Jackson
McLaughlin, M. J.....Jackson
McLauthlin, Herbert B.....M
Meads, J. B.....Jackson
Miller, J. L.....M
Munro, C. D.....Jackson
Munro, James E.....Jackson
Murphy, B. M.....M
Newton, R. E.....Jackson
Olesky, S.....M
O'Meara, James J.....Jackson
Otic, Grant L.....M
Payne, Andrew K.....Jackson
Phillips, G.....Jackson
Porter, H. W.....Jackson
Pray, Frank F.....Jackson
Pray, George R.....Jackson
Ransom, F. G.....Jackson
Riley, Philip.....Jackson
Roberts, Arthur J.....(E)..Jackson
Schepeler, C. W.....Brooklyn
Scheurer, Peter Arthur...Manchester
Schmidt, T. E.....Jackson
Scott, John A.....M
Seybold, Edward G.....M
Shaeffer, A. M.....Jackson
Sill, Henry W.....Jackson
Sirhal, Alfred M.....M
Smith, Dean W.....Jackson
Speck, John W.....Jackson
Southwick, W.....M
Stewart, L. L.....Jackson
Sugar, Samuel.....M
Susskind, M. V.....M
Tate, Cecil E.....M
Thayer, E. A.....Jackson
Thalner, L. F.....Jackson
Torwick, E. T.....Jackson
Townsend, J. W...Vandercook Lake
Tuthill, F. S.....Concord
Van Schoick, John D.....Hanover
Van Schoick, Frank.....Jackson
VanWagnen, F. I.....M
Vivirski, Edward E.....M
Wertenberger, M. D.....Jackson
Wholihan, John W..Michigan Center
Wickham, W. A.....M
Wilson, E. G.....Jackson
Wilson, N. D.....Jackson
Winter, G. E.....Jackson
Woodward, George D.....Jackson

Kalamazoo County

Aach, Hugo.....M
Alexander, C. A.....Kalamazoo
Anderson, K. A.....Kalamazoo
Andrews, Sherman.....M
Armstrong, Robert J.....Kalamazoo
Banner, Lawrence R.....Kalamazoo
Barnebee, J. W.....Kalamazoo
Barrett, F. Elizabeth.....Kalamazoo
Behan, Gerald W.....Galesburg
Benjamin, Margaret.....Kalamazoo
Bennett, C. L.....Kalamazoo
Bennett, Keith.....M
Berry, J. F.....Kalamazoo
Bodmer, H. C.....Kalamazoo
Borgman, Wallace.....M
Boys, C. E.....Kalamazoo
Brooks, Ervin, D...(E)..Kalamazoo
Brown, I. W.....Kalamazoo
Burns, J. T.....Kalamazoo
Caldwell, George H.....Kalamazoo
Cobb, Horace R.....Kalamazoo
Cook, R. G.....Kalamazoo
Crane, W. B.....M
Crawford, Kenneth.....M
Dahlstrom, Doris.....Kalamazoo

★Died in Military Service

Den Bleyker, Walter.....Kalamazoo
DeWitt, L. H.....Kalamazoo
DeWitt, Norman.....M
Dowd, B. J.....M
Doyle, F. M.....M
Ertell, Wm. Francis.....Kalamazoo
Fast, R. B.....Kalamazoo
Fopeano, John V.....M
Fulkerson, C. B.....Kalamazoo
Fuller, R. T.....Kalamazoo
Fuller, Paul.....M
Gerstner, Louis.....Kalamazoo
Gilding, Joseph.....M
Glenn, Audrey.....Chicago, Ill.
Goodhue, Lolita.....Kalamazoo
Grant, Frederick E.....Kalamazoo
Gray, Arthur S.....M
Green, William.....Kalamazoo
Gregg, U. Sherman.....Kalamazoo
Harter, Randolph S.....Schoolcraft
Heersma, H. S.....Kalamazoo
Hildreth, R. C.....Kalamazoo
Hobbs, Edw. J.....Galesburg
Hoebeke, Wm. G.....Kalamazoo
Holder, Charles.....M
Howard, W. H.....Galesburg
Hubbell, R. J.....Kalamazoo
Huyser, Wm. C.....Kalamazoo
Irwin, Wm. D.....M
Jackson, Howard C.....M
Jackson, John B.....Kalamazoo
Jennings, W. O.....Kalamazoo
Kavanaugh, Wm. R.....M
Kenzie, W. N.....Glendale, Calif.
Klerk, W. J.....M
Koestner, Paul.....M
Kuhs, Milton, L.....M
Lambert, R. H.....Kalamazoo
Lang, W. W.....Kalamazoo
Lavender, Howard.....Kalamazoo
Light, Richard.....Kalamazoo
Light, S. Rudolph.....Kalamazoo
Littig, John.....Kalamazoo
MacGregor, J. R.....M
Malone, James G.....M
Margolis, Frederick.....Kalamazoo
Marshall, Don.....M
Marshall, Evelyn.....Kalamazoo
McCarthy, J. S.....Kalamazoo
McIntyre, Charles H. .....M
Moe, Carl Rex.....M
Moffat, Gordon.....Kalamazoo
Morter, Roy A.....Kalamazoo
Nell, Edward R.....M
Nibbelink, B.....Kalamazoo
Okun, M. H.....M
Osborne, Charles E.....M
Patmos, Martin.....M
Peelen, J. W.....M
Peelen, Matthew.....M
Perry, Clifton.....Kalamazoo
Pratt, F. A.....Kalamazoo
Prentice, Hazel R.....Kalamazoo
Rigterink, G. H.....M
Rigterink, H. A.....Kalamazoo
Rockwell, Donald C.....Kalamazoo
Ryan, F. C.....M
Sage, Edward D.....Kalamazoo
Scholten, D. J.....Kalamazoo
Scholten, Wm.....Kalamazoo
Schrier, C. M.....M
Shrier, Paul.....M
Schrier, Thomas.....M
Scott, Wm. A.....M
Shackleton, Wm. E.....Kalamazoo
Shepard, B. A.....Kalamazoo
Shook, R. W.....M
Simpson, R. W.....Kalamazoo
Snyder, Roscoe F.....Kalamazoo
Sofen, Morris B.....M
Southworth, M. N.....M
Stryker, Homer H.....Kalamazoo
Upjohn, E. G.....Kalamazoo
Upjohn, L. N.....Kalamazoo
Van Urk, Thomas.....Kalamazoo
Verhage, Martin D.....M
Volderauer, John C.....M
Wagenaar, E. H.....M
Walker, Burt D.....Kalamazoo
Wescott, L. E.....Kalamazoo
Wilbur, E. P.....Kalamazoo
Youngs, A. S.....Kalamazoo
Youngs, C. A.....Kalamazoo
Zolen, Margaret.....Kalamazoo

Kent County

Adams, F. A.....M
Aitken, George T.....M
Alexander, Marshall O..Grand Rapids
Alfenito, Felix S.....M
Allen, R. V.....Grand Rapids
Bachman, G. A.....Grand Rapids
Baert, George H.....Grand Rapids
Baker, Abel J.....Grand Rapids
Ballard, M. S.....Grand Rapids
Balyeat, Gordon W.....M
Barber, Clarence H....Grand Rapids
Batts, Martin .....M
Beaton, James H.....M
Beeman, Carl B.....M
Beeman, C. E.....Grand Rapids
Beets, W. Clarence.....M
Bell, Charles M.....M
Bettison, Wm. L.....M
Billings, Elton P.....Grand Rapids
Blackburn, Henry M...Grand Rapids
Bloxsom, P. W.....Grand Rapids
Boelkins, Richard C.....M
Boet, F. A.....Grand Rapids
Boet, John .....M
Bond, Geo. L.....Grand Rapids
Bosch, L. C.....Grand Rapids
Brace, Fred .....M
Brayman, C. W.....Cedar Springs
Brink, Russell .....M
Brook, Jacob D.....Grandville
Buesing, O. R.....M
Buist, S. J.....Grand Rapids
Bull, Frank L.....Sparta
Burleson, John S.....Grand Rapids
Burling, W. M.....Grand Rapids
Burroughs, Frank M...Grand Rapids
Butler, Wm. J.....Grand Rapids
Byers, Earl J.....Grand Rapids
Byrd, Mary Lou.....Grand Rapids
Campbell, Alexander ..Grand Rapids
Carpenter, Luther C.....M
Chadwick, W. L.....M
Chamberlain, L. H.....Grand Rapids
Chandler, Donald .....Grand Rapids
Claytor, R. W.....Grand Rapids
Collisi, Harrison S.....M
Colvin, W. G.....M
Corbus, Burton R.....Grand Rapids
Cosgrove, Wm. J.....M
Crane, Charles V.....Grand Rapids
Crane, Harold D.....M
Dales, Ernest W.....Grand Rapids
Damstra, H. J.....M
Davis, D. B.....M
Dean, Alfred W.....Grand Rapids
DeBoer, Guy Wm.....M
DeMaagd, Gerald.....Rockford
DeMol, Richard J.....Grand Rapids
Denham, R. H.....Grand Rapids
Denham, Robert H., Jr.....M
DePree, Isla G.....Grand Rapids
DePree, Joseph .....Grand Rapids
DeVel, Leon .....M
DeVries, Daniel.....M
Dewar, M. M.....Grand Rapids
Dick, Mark W.....M
Dickstein, Bernard .....M
Diskey, Donald .....Grand Rapids
Dixon, Willis L.....Grand Rapids
Doran, Frank .....Grand Rapids
Droste, James C.....Grand Rapids
Duiker, Henry .....Grand Rapids
Eaton, Robert M.....M
Eggleston, H. R.....Grand Rapids
Failing, John F.....M
Fannoff, Frank L.....Grand Rapids
Farber, Charles E.....M
Faust, L. W.....Grand Rapids
Fee, G. Manson.....M
Fellows, Kenneth E.....M
Ferguson, James .....M
Ferguson, Lynn A.....Grand Rapids
Ferguson, Ward S.....Grand Rapids
Ferrand, L. .....M
Fitts, Ralph L.....M
Flynn, J. D.....M
Foshee, J. C.....Grand Rapids
Frantz, C. H.....M
Freyling, Robert .....M
Fuller, E. H.....Grand Rapids
Gaikema, E. W.....Grand Rapids
Geenen, C. J.....Grand Rapids
Gibbs, F. F.....Grand Rapids
Gillett, O. H.....Grand Rapids
Grant, Lee O.....Grand Rapids
Graybiel, George .....Caledonia
Griffith, L. S.....M
Haeck, Wm. .....M
Hagerman, D. B.....Grand Rapids
Hammand, T. W..(R) Grand Rapids
Hardy, Faith F.....Grand Rapids
Hayes, L. W.....Howard City
Heetderks, Dewey R..Grand Rapids
Henry, James, Jr.....Grand Rapids
Herrick, Ruth .....Grand Rapids
Hill, A. Morgan.....M
Hilt, Lawrence M.....M
Hodgen, J. T.....Grand Rapids
Holcomb, J. W.....Grand Rapids
Holdsworth, M. J.....M
Holkeboer, H. D.....Grand Rapids
Hollander, Stephen .....M
Hoogerhyde, Jack .....M
Houghton, G. D.....Caledonia
Hufford, A. R.....Grand Rapids
Hunderman, Edward ..Grand Rapids
Hutchinson, Robert J..Grand Rapids
Hyland, W. A.....Grand Rapids
Ingersoll, C. F.....M
Irwin, Thomas C.....Grand Rapids
Jameson, Fred M.....M
Jaracz, W. J.....Grand Rapids
Jarvis, Charles .....Grand Rapids
Kelly, Robert E.....M
Kemmer, Thomas R....Grand Rapids
Kendall, Eugene L....Grand Rapids
Klaus, C. D.....M
Kniskern, P. W.....M
Kooistra, Henry P.....Grand Rapids
Kratz, E. Ransom.....M
Kremer, John .....Grand Rapids
Kreulen, H. J.....Grand Rapids
Kriekard, P. J.....Grand Rapids
Laird, Robert G.....Grand Rapids
Lamb, George F.....Grand Rapids
Lanning, N. E.....Grand Rapids
Lawrence, Howard C..Grand Rapids
Lentini, Joseph R.....M
LeRoy, Simeon .....Grand Rapids
Lieffers, Harry, ...Grand Rapids
Logie, James W.....Grand Rapids
Lyman, Wm. D.....Grand Rapids
MacDougall, Clarice L...Grand Rapids
McCandless, Robert ...Grand Rapids
MacDonald, Allan .....M
McDonell, James A.....M
Marrin, M. M.....M
Marsh, J. P.....Grand Rapids
Martin, A. M.....Grand Rapids
Maurits, Reuben .....Grand Rapids
McCormick, John K.....M
McKenna, J. L.....M
McKinley, L. M.....Grand Rapids
McRae, John H.....Grand Rapids
Mehney, Gayle H.....Grand Rapids
Miller, J. Duane.....M
Miller, John J.....Marne
Mitchell, H. C.....M
Mitchell, W. B.....Grand Rapids
Moen, Cornetta G.....Grand Rapids
Moleski, Leo .....M
Moleski, Stanley .....Grand Rapids
Moll, Arthur M.....Grand Rapids
Mollman, Arthur ....Grand Rapids
Moore, Vernor M.....Grand Rapids
Mouw, Richard .....M
Mulder, J. D.....Grand Rapids
Murphy, M. J.....M
Nelson, A. R.....M
Noordewier, Albert ...Grand Rapids
Northouse, Peter B.....Grandville
Northrup, Wm. .....Ionia
Oliver, W. W.....Grand Rapids
Patterson, P. Wilfred..Grand Rapids
Payne, C. Allen.....M
Pedden, J. R., Jr.....Grand Rapids
Phillips, J. W.....Grand Rapids
Posthuma, Millard .....M
Pott, A. L.....M
Pyle, Henry J.....Grand Rapids
Ragsdale, L. V.....Grand Rapids
Ralph, L. Paul.....M
Reed, Torrance .....Grand Rapids
Reus, William F.....Grand Rapids
Rigterink, J. W.....Grand Rapids
Riley, G. L.....Grand Rapids
Robb, Chas. S.....Grand Rapids
Roberts, Mortimer E...Grand Rapids
Robinson, Harold .....Grand Rapids
Rodgers, W. L.....Grand Rapids
Roth, Emil M.....M
Rogalski, Floyd J.....M
Schermerhorn, L. J....Grand Rapids
Schuitema, Donald .....M
Schnoor, E. W.....Grand Rapids
Schnute, Louise F.....Grand Rapids
Scully, Ray E.....M
Sevensma, Elisha S....Grand Rapids
Sevey, L. E.....Grand Rapids
Shepard, B. H.....Lowell
Shellman, Millard W.....M

*Died in Military Service.

Sluyter, J. S.....M
Smith, A. B.....Grand Rapids
Smith, Edwin M.....Grand Rapids
Smith, Ferris N.....Grand Rapids
Smith, R. Earle.....Grand Rapids
Snapp, Carl F.....Grand Rapids
Snyder, Clarence H....Grand Rapids
Southwick, G. Howard.Grand Rapids
Steffensen, W. H.....M
Stonehouse, G. G.....Grand Rapids
Stover, Virgil E.....M
Sugg, Cullen E.....Grand Rapids
Sus Strong, Carl A....Grand Rapids
Swanson, H. C.....M
Swenson, Leland L.....M
Ten Have, J.....Grand Rapids
Tesseine, A. J.....M
Teusink, J. H.....Cedar Springs
Thompson, A. B. (E)..Grand Rapids
Thompson, Athol B....Grand Rapids
Thompson, P. L.....Grand Rapids
Tidey, Marcus B.....Grand Rapids
Tiffany, Jos. C.....Grand Rapids
Torgerson, Wm. R.....Grand Rapids
Van Belois, Harvard J..Grand Rapids
Van Bree, R. S.....Grand Rapids
Vanden Berg, Henry J. Grand Rapids
Vander Meer, Ray.....M
Van Duine, H. J.....Byron Center
Vann, N. S.....Grand Rapids
Van Noord, Gelmer A..Grand Rapids
Van Solkema, Andrew..Grand Rapids
Van Solkema, Arthur.....M
Van Woerkom, Daniel.Grand Rapids
Van Zwaluwenberg, Benj. R.....M
Veldman, Harold E....Grand Rapids
Veenboer, Wm. H.....Grand Rapids
Venema, J. R.....Grand Rapids
Vis, Wm. R.....Grand Rapids
Vyn, J. D.....Grand Rapids
★Warmenhoven, Simon..Grand Rapids
Warnshuis, F. C. (E)..Grand Rapids
Webb, Rowland .....Grand Rapids
Webber, Jerome .....M
Wedgwood, L. G.....Grandville
Wells, Merrill .....Grand Rapids
Wenger, Aaron V.....Grand Rapids
Wenger, John N.....Coopersville
Whalen, John .....M
Whinery, Joseph B.....Grand Rapids
Willits, P. W.....Grand Rapids
Wilson, Wm. E. (R)..Grand Rapids
Winfield, Emery D....Grand Rapids
Winter, Garrett E.....Grand Rapids
Woodburne, A. R.....M
Wright, John M.....Grand Rapids
Wright, Thomas B.....Grand Rapids
Wurz, John F.....M
Yegge, J. P.....Kent City

Lapeer County

Best, H. M.....Lapeer
Bishop, G. C.....Almont
Blakeslee, Merton C.....Lapeer
Chapin, Clarence D....Columbiaville
Dorland, Clark.....M
Jackson, G. C.....M
McBride, J. R.....Lapeer
McLeod, K. W.....Lapeer
Merz, Henry G.....Lapeer
O'Brien, Daniel J.....Lapeer
Rehn, Adolph T.....Lapeer
Rohn, Mary.....Lapeer
Smith, G. L.....Imlay City
Thomas, J. Orville....North Branch
Tinker, F. A.....(E).....Lapeer
Zemmer, H. B.....Lapeer

Lenawee County

Blair, Thomas.....Adrian
Blanchard, L. E.....Hudson
Bland, J. P.....Adrian
Campbell, C. A.....M
Claflin, G. M.....Adrian
Claxton, W. T.....M
Hall, George C.....M
Hammel, H. H.....M
Hardy, P. B.....Tecumseh
Heffron, Howard H.....Adrian
Helzerman, Ralph F.....M
Hewes, A. B.....Adrian
Hornsby, W. B.....Clinton
Howland, F. A.....Adrian
Iler, Harris D.....M
Jewett, Wm. E., Jr.....Adrian
Lamley, Arthur E.....Blissfield
McKenzie, W. S.....Adrian
McCue, Francis J. Jr.....M
McCue, F. J., Sr.....Hudson
Marsh, R. G. B.....M
Miller, Perry Lynford.....M
Morden, Elsi T.....Adrian
Pasternacki, Arthur S.....M
Patmos, Bernard.....M
Peters, W. L.....Morenci
Rawson, A. P.....M
Rogers, J. D.....M
Spalding, I. L.....Hudson
Stafford, Leo J.....Adrian
Van Dusen, C. A.....Blissfield
Wynn, G. H.....M

Livingston County

Brigham, Jeannette.....Howell
Cameron, Duncan A.....M
Coughlin, Florence J.....Howell
Crandell, Claire H.....Howell
Duffy, Ray M.....Pinckney
Finch, E. D.....Howell
Glenn, B. H.....Fowlerville
Hayner, R. A.....M
Hendren, J. J.....Fowlerville
Hill, Harold C.....M
Huntington, H. G.....Howell
Laboe, Edward W.....Howell
Leslie, G. L.....M
McGregor, Archie J.....Brighton
McDowell, Guy Marshall.....Howell
Rednor, Daniel J.....Howell
Sigler, Hollis L.....Howell
Stephens, D. C.....M
Thal, Wm.....Howell

Luce County

Bohn, Frank P.....(E)..Newberry
Campbell, E. H.....Newberry
Franklin, Sidney.....Newberry
Gibson, R. E.....Newberry
Lance, Paul E.....M
Perry, Henry E.....Lakeland, Fla.
Purmort, Wm. R., Jr.....Newberry
Spinks, Robert E.....Newberry
Surrell, M. A.....M
Swanson, Geo. F.....M
Toms, Chas. B.....Newberry

Macomb County

Banting, O. F.....Richmond
Berry, Henry G...(E)..Mt. Clemens
Croman, Joseph M., Jr..Mt. Clemens
Croman, Joseph M., Sr.....
(E)..Mt. Clemens
Duerloo, H. W.....M
Dudzinski, Edmund J.....M
Engels, J. A.....Richmond
Isbey, E. K.....Centerline
Kane, W. J.....Mt. Clemens
Lane, W. D.....Romeo
Maguire, A. J.....M
Moore, G. F.....Mt. Clemens
Parker, B. Morgan.....Utica
Reichman, Joseph J.....M
Rivard, Charles L.....M
Roth, G. E.....M
Ruedisueli, Clarence A.....Roseville
Rothman, A. M.....M
Salot, R. F.....M
Scher, Joseph N.....M
Stone, Elizabeth A.....Romeo
Sturm, Fred A.....St. Clair Shores
Thompson, A. A.....Mt. Clemens
Ullrich, R. W.....Mt. Clemens
Wellard, Henry C.....M
Whitley, Alec.....St. Clair Shores
Wilde, M. M.....Warren
Wiley, D. Bruce.....Utica
Wiley, Herbert H.....Utica
Wolfson, V. H.....Mt. Clemens

Manistee County

Grant, C. L.....Manistee
Hansen, E. C.....M
Konopa, John F.....M
Lewis, Lee A.....Manistee
MacMullen, Harlen D.....Manistee
Miller, E. B.....Manistee
Norconk, Ward H.....Bear Lake
Oakes, Ellery A.....Manistee
Ogilvie, G. D.....M
Quinn, Henry M.....Copemish
Ramsdell, Homer A.....Manistee

Marquette-Alger County

Bennett, Arthur K.....Marquette
Berry, Robert F.....Marquette
Bertucci, J. P.....Ishpeming
Burke, R. A.....Palmer
Bottum, Charles N.....Marquette
Casler, W. L.....Marquette
Cooperstock, M.....Marquette
Corcoran, W. A.....Ishpeming
Drury, Charles P.....Marquette
Elzinga, E. R.....Marquette
Erickson, Arvid W.....Ishpeming
Fennig, F. A.....M
Hanelin, H. A.....M
Hartt, P. P.....Ishpeming
Hirwas, C. L.....Marquette
Hornbogen, D. P.....M
Howe, L. W.....Marquette
Janes, R. Grant.....M
Keskey, George I.....Marquette
Lambert, W. C.....Marquette
LeGolvan, C.....Marquette

★Died in Military Service.

McCann, Neal J.....Ishpeming
Mudge, W. A.....Negaunee
Nicholson, J. B.....M
Niemi, O. I.....M
Picotte, Wilfrid S.....Ishpeming
Schutz, W. J.....M
Sicotte, Isaiah .....Michigamme
Talso, Jacob.....Ishpeming
Vandeventer, V. H.....Ishpeming
Van Riper, Paul.....Champion
Waldie, George McLeod..Ishpeming
Wickstrom, Geo.....Munising

Mason County

Benjamin, Clayton C.....Ludington
Blanchette, Victor J.....Scottville
Comodo, Nicholas M.....M
Goulet, L. J.....Ludington
Hoffman, H. E.....M
Hunt, Ivan L.....Scottville
Ostrander, R. A.....M
Paukstis, Charles.....Ludington

Mecosta-Osceola-Lake Counties

Bruggema, Jacob .....Evart
Chess, Leo F.....Reed City
Franklin, Benjamin L.....Remus
Hall, Clifton.....Big Rapids
Ivkovich, Paul.....M
Kilmer, Paul B.....Reed City
Klein, J. Paul.....M
MacIntyre, Donald.....Big Rapids
McGrath, V. J.....Reed City
Merlo, F. A.....Big Rapids
Peck, Louis K.....Berryton
Phillips, R. W.....M
Treynor, Thomas P.....Big Rapids
White, J. A.....Big Rapids
Yeo, Gordon H.....Big Rapids

Medical Society of North Central Counties
Otsego-Montmorency-Crawford-Oscoda-Roscommon-Ogemaw Counties

Beeby, Robt. J.....West Branch
Clippert, C. G.....Grayling
Coulter, Keith D.....Gladwin
Drescher, Geo. A.....Lewiston
Egle, Joseph L.....Gaylord
Harris, Levi A.....(E)..Gaylord
Hendricks, Henning V.....Kalkaska
Jardine, Hugh.....West Branch
Keyport, C. R.....Grayling
Lanting, Roelof.....M
Martzowka, M. A.....Roscommon
McDowell, Douglas B.....M
McKillop, G. L.....Gaylord
Peckham, Richard.....Gaylord
Sargent, Leland E.....Jackson
Stealy, Stanley A.....M

Menominee County

DeWane, F. J.....Menominee
Flanagan, Clarence B....Menominee
Heidenreich, John R.....M
Jones, Wm. S.....Menominee
Kaye, J. T.....Menominee
Kerwell, K. C.....Stephenson
Mason, Stephen C.....Menominee
Peterson, A. R.....Daggett
Sawbridge, Edward.(E)..Stephenson
Sethney, Henry T.....Menominee
Sethney, Walter F.....M
Towey, J. W.....Powers

Midland County

Ballmer, Robert S.....Midland
Gay, Harold H.....Midland
Grewe, N. C.....Midland
High, C. V., Jr.....Midland
Howe, Irvin M.....Midland
Linsenmann, Karl.....Midland
MacCallum, Charles.....Midland
Maynard, W. A.....Coleman
Meisel, Edward H.....M
Nicholas, Mildred.....Midland
Pike, Melvin H.....Midland
Rice, Robert E.....Midland
Sherk, J. H.....Midland
Sjorlander, Gust.....Midland
Towsley, W. D.....Midland
Von Haitinger, Kalmon S.....M

Monroe County

Acker, Wm. F.....Monroe
Ames, Florence.....Monroe
Balk, A. C.....Monroe
Barker, Vincent L.....M
Blakey, L. C.....Monroe
Bond, W. W.....M
Cohen, H. Herbert.....M
Denman, D. C.....M
Dusseau, S. V.....(E)..Erie
Ewing, R. T.....Monroe
Fieldhouse, B. J.....Ida
Flanders, J. P.....M
Gelhaus, Wm. J.....Monroe
Golinvaux, C. J.....Monroe
Goodman, Louis.....M
Heffernon, John F.....Carleton
Hensel, Hilda .....Monroe
Heustis, Albert E.....Monroe
Hunter, M. A.....M
Johnson, A. Esther.....Monroe
Landon, Herbert W.....Monroe
Long, Edgar C.....M
Long, Sara .....Monroe
McDonald, T. A.....Monroe
McGoech, R. W.....Monroe
McMillan, J. H.....Monroe
Meck, H. L.....Dundee
Parmelee, O. E.....Lambertville
Penzotti, Stanley .....M
Pinkus, Hermann .....Monroe
Reisig, A. H.....M
Sanger, Emerson J.....Monroe
Siffer, J. J.....Monroe
Stolpestad, C. T.....M
Tomlinson, L. H.....Newport
Wagar, Spencer.....Rockwood
Williams, R. J.....M
Williamson, George W.....Dundee

Muskegon County

Anderson, A. J.....Muskegon
Anderson, Axel W...Lakewood Club
August, R. V.....Muskegon
Bartlett, F. H.....Muskegon
Barnard, Helen.....Muskegon
Beers, Charles.....Muskegon Hgts.
Benedict, A. L.....M
Bloom, C. J.....Muskegon
Boyd, D. R.....Muskegon
Bradshaw, Park S.....Muskegon
Chapin, Wm. S.....Muskegon Hgts.
Closz, H. F.....Muskegon
Cohan, Sol G.....Muskegon
Collier, C. C.....Whitehall
D'Alcorn, Ernest.....Muskegon
Dasler, A. F.....M
Derezinski, Clement F.....Muskegon
Diskin, Frank.....M
Douglas, Robert.....M
Durham, C. J.....Muskegon
Dykhuisen, Harold D.....Muskegon
Eckerman, C. T.....Muskegon
Fillingham, Enid.....Muskegon
Fleischman, C. B.....Muskegon
Fleishman, Norman.....M
Foss, Ed. O.....Muskegon
Garber, F. W., Jr.....Muskegon
Garland, J. O.....Muskegon
Gillard, James.....M
Goltz, Martha H.....Montague
Griffith, Robt. M.....M
Hagen, Wm. A.....Muskegon
Hannum, F. W.....Muskegon
Harrington, A. F.....Muskegon
Harrington, R. J.....Muskegon
Hartwell, S. W.....M
Heneveld, John.....Muskegon
Holly, Leland E.....Muskegon
Holmes, Roy H.....M
Jackson, S. A.....Muskegon
Kane, Thomas J.....M
Keilin, Marie .....Muskegon
Kerr, H. J.....M
Kniskern, E. L.....Muskegon
LaCore, O. M.....Muskegon Hts.
Lange, E. W.....Muskegon
Lauretti, Emil.....Muskegon
Laurin, V. Samuel.....Muskegon
LeFevre, Louis.....M
LeFevre, Wm. M.....Muskegon
Loder, Leonel Lewis.....Muskegon
Loomis, John L.....Muskegon
Mandeville, C. B.....Muskegon
Medema, Paul E.....Muskegon
Meengs, M. B.....M
Miller, Philip L.....M
Morford, F. N.....Muskegon
Morse, Bertram W.....M
Mulligan, A. W.....Muskegon
Oden, Constantine L.....Muskegon
Petkus, Antonie.....Muskegon
Pettis, Emmett.....Muskegon
Powers, Lunette.....Muskegon
Price, Leonard.....M
Pyle, H. J.....Muskegon
Risk, R. A.....Muskegon
Risk, R. D.....M
Scholle, N. W.....M
Ryan, Wm. J. J.....Muskegon
Sears, Richard.....Muskegon
Stone, Maxwell E.....Muskegon
Struthers, J. N. P.....Muskegon
Swartout, W. C.....Muskegon
Teifer, Charles A.....Muskegon
Thieme, S. W. .....Ravenna
Thornton, E. S.....Muskegon
Wiersma, Silas C.....Muskegon
Wilke, C. A.....Montague
Wilson, P. S.....Muskegon

Newaygo County

Black, B. F.....Holton
Deur, T. R.....Grant
Geerlings, Lambert.....Fremont
Geerlings, Lewis J.....M
Geerlings, Willis.....Fremont
Gordon, B. F.....M
Moore, H. R.....Newaygo
O'Neill, J. W.....White Cloud
Saxen, Raymond T.....White Cloud
Stryker, O. D.....Fremont
Tompsett, Arthur C.....Hesperia

Northern Michigan Medical Society
Antrim-Charlevoix-Cheboygan-Emmet Counties

Benson, A.H.....Mancelona
Beuker, Bernard.....East Jordan
Blum, Benjamin B.....M
Burns, Dean C.....Petoskey
Chapman, W. E.....Cheboygan
Conkle, Guy C.....Boyne City
Conti, Joseph.....M
Conway, Wm.....M
Duffie, Don Hastings..Central Lake
Frank, Gilbert E....Harbor Springs
Gervers, John H. R.....Bellaire
Giffords, Mark.....M
Gilpin, John H.....Cheboygan
Hegener, A. J.....Petoskey
Larson, Walter E.....Cheboygan
Lashmet, Floyd H.....Petoskey
Lilgas, Harris V.....M
Litzenburger, A. F.....Boyne City
Mast, W. H.....Petoskey
Mayne, Frederick C.....Cheboygan
McCarroll, James C.....Cheboygan
McCune, Wm. Stanley.....M
Mcleod, M. M.....Petoskey
McMillan, Fraley.....Charlevoix
McMillan, Lyle D..Mackinaw City
Miller, Samuel L.....M
Palmer, Russell,.....St. James
Parks, W. H.....Petoskey
Reed, Wilbur F....(E)..Cheboygan
Rodgers, John.....Bellaire
Saltonstall, G. B.....Charlevoix
Stringham, J. R.....Cheboygan
Van Dellen, Jerrian.....East Jordan
Winter, Joseph A.....M
Wood, George.....Onaway

Oakland County

Abbott, V. C.....M
Arnkoff, Harry .....Pontiac
Aschenbrenner, Z. R.....Farmington
Baker, Frederick A.....Pontiac
Baker, Robert H.....Pontiac
Barker, Howard B.....Pontiac
Bauer, Ernest W.....Hazel Park
Beattie, W. G.....Ferndale
Beck, O. O.....Birmingham
Benning, C. H.....M
Berg, Richard H.....Oxford
Borland, Alex .....Pontiac
Burke, Chauncey G.....Pontiac
Boucher, R. E.....M
Butler, Samuel A.....Pontiac
Calhoun, T. Ethel.....Birmingham
Campbell, Malcolm D.....M
Capano, Oreste A.....Pontiac
Carr, Wm. H.....Holly
Christie, E. A.....Pontiac
Christie, J. W.....M
Church, J. E.....Pontiac
Cobb, Leon F.....Pontiac
Cobb, Thomas H.....Pontiac
Cooper, Robt. J.....M
Crissman, H. C.....Ferndale
Cudney, Ethan B.....Pontiac
Dahlgren, Carl.....Keego Harbor
Darling, C. G., Jr.....Pontiac
Dobski, Edwin J.....M
Domeier, L. H.....M
Ekelund, Clifford T.....Pontiac
Farnham, L. A.....Pontiac
Faulconer, Albert .....M
Ferris, Ralph G.....Birmingham
Fitzpatrick, Francis .....Pontiac
Flick, Earl J.....M
Flick, John R.....Royal Oak
Foust, Earl .....M
Fox, John W.....Pontiac
Francis, Donald .....M
Furlong, Harold A.....M
Gaensbauer, Ferdinand .....Pontiac
Gariepy, Bernard F.....Royal Oak
Gatley, C. R.....M
Gatley, Warren L.....Pontiac
Gehringer, Norman F.....M
Geib, Ormond D.....Rochester
Gerls, Frank B.....Pontiac
Gibson, Wellington C.....Pontiac
Gordon, J. H.....Birmingham
Grant, Wm. A.....Milford
Green, Wm. M.....Pontiac
Hackett, Daniel J.....Pontiac
Halsted, Lee H.....Farmington
Hammer, Carl W.....M
Hammonds, E. E.....M
Harvey, Campbell .....Pontiac
Hasner, R. B.....Royal Oak
Hassberger, J. B.....M
Hathaway, Clarence L...Lake Orion
Hathaway, Wm. .....Rochester
Henry, Colonel R. C.....Ferndale
Hensley, C. B.....Lake Orion
Howlett, E. V.....Pontiac
Hoyt, D. F.....M
Hubert, John R.....M
Huffman, M. R.....Milford
Hume, T. W. K.....Auburn Heights
Hurst, Daniel D.....Pleasant Ridge
Hutchinson, W. G.....Pontiac
Jones, Morrell M....Drayton Plains
Kemp, Felix J.....Pontiac
Kemp, W. Lloyd.....Birmingham
Kimball, A. S.....Pontiac
Kirkup, Norman N.....Hazel Park
Koehler, Wm. H.....Royal Oak
Lambie, John S.....Pontiac
Lambert, Alvin G.....Ferndale
Larson, B. T.....Pontiac
Lass, E. H.....M
Lewis, S. M.....Ferndale
Little, J. W.....M
Lockwood, C. E.....Holly
MacKenzie, O. R.....Walled Lake
Margrave, Edmund D....Royal Oak
Markley, John M.....M
Mason, Robt. J.....M
McConkie, J. P.....Birmingham
McEvoy, Francis J.....M
McNeill, H. H.....Pontiac
Meinke, Herman A.....Hazel Park
Mercer, Frank A.....Pontiac
Merrill, Lionel N.....Royal Oak
Mitchell, B. M.....Pontiac
Monroe, John D.....Pontiac
Mooney, C. A.....Ferndale
Needle, Francis .....M
Newcomb, Arnold B.....Berkley
Norup, John .....Berkley
Nosanchuk, Joseph.....M
Ohlmacher, A. P.....M
Olsen, Richard E.....M
★Osgood, W. S.....
Pauli, Theodore H.....M
Pool, H. H.....Pontiac
Porritt, Ross J.....M
Ports, Preston W.....M
Reid, F. T.....Clawson
Rennell, E. J.....Pontiac
Riker, Aaron D.....Pontiac
Roehm, Harold R.....Birmingham
Rowley, Laurie G....Drayton Plains
Russell, Vincent P.....M
St. John, Harold A.....Pontiac
Schlecte, E. Carl.....M
Schlecte, Eva Mirian.....Rochester
Schoenfeld, John B.....M
Seaborn, A. J.....Royal Oak
Shadley, Maxwell .....M
Sheffield, L. C.....Pontiac
Simpson, E. K.....Pontiac
Smith, Carleton A.....M
Smith, Donald S.....M
Smith, Ellen .....Pontiac
Spears, M. L.....Pontiac
Spencer, Lloyd H.....M
Spoehr, Eugene L.....M
Spohn, Earl W.....M
Stahl, Harold F.....Oxford
Stanley, Wm. F.....M
Starker, C. T.....Pontiac
Steinberg, Norman .....Royal Oak
Stolpman, A. K.....M
Sutton, Palmer E.....Royal Oak
Swickle, Edward F.....Royal Oak
Tuck, Raymond G.....Pontiac
★Terry, Stewart .....
Uloth, Milton J.....Ortonville
Vatz, Jack A.....Pontiac
Wagley, P. V.....M
Wagner, Ruth E.....Royal Oak
Wentz, A. E.....M
Young, Arthur R.....Pontiac
Zonnis, Marian E.....Pontiac

Oceana County

Day, Clinton.....Hart
Flint, Charles.....M
Hayton, A. R.....Shelby
Heard, Wm.....Pentwater
Heysett, N. W.....Austin, Texas
Jensen, Viggo.....Shelby
Lemke, Walter M.....M
Munger, L. P.....Hart
Nicholson, John H.....Hart
Reetz, F. A.....Shelby
Robinson, W. Gordon.....M
Wood, Merle G.....Hart

Ontonagon County

Bender, Jesse L.....Mass
Hogue, H. B.....Ewen
Pinkerton, W. J.....Ramsay
Rubenfeld, S. H.....M
Strong, W. F.....Ontonagon

Ottawa County

Beernink, E. H.....Grand Haven
Bloemendaal, D. C.....Zeeland
Bloemendal, W. B.....Grand Haven
Boone, Cornelius E.....Zeeland
Clark, Nelson H.....M
Cook, Carl S.....M
Costello, C. V.....Holland
DeVries, H. G.....Holland
De Witt, S. L.....Grand Haven
Hamelink, M. H.....Holland
Harms, H. P.....M
Kemme, Gerrit.....Zeeland
Kitchel, John.....Grand Haven
Kitchel, Mary.....Grand Haven
Kools, Wm. C.....Holland
Leenhouts, Abraham..(E)..Holland

★Died in Military Service.

Nichols, Rudolph H.....Holland
Nykamp, Russell.....Zeeland
Presley, Wm. J.....Grand Haven
Rypkema, Willard M.....M
Stickley, A. E.....Coopersville
Ten Have, Ralph.....Grand Haven
Timmerman, E. C.....M
Van Appledorn, Chester J...Holland
Van Der Berg, E.....Holland
Van Der Velde, O.....Holland
Westrate, Wm.....Holland
Winter, John K.....Holland
Winter, Wm. G.....M

Saginaw County

Ackerman, G. L.....Saginaw
Bagley, U. S.....Saginaw
Bagshaw, David E.....Saginaw
Berberovich, T. F.....Saginaw
Bishop, H. M.....M
Brock, W. H.....Saginaw
Bruton, Martin F.....Saginaw
Busch, Frank J.....Saginaw
Butler, M. G.....M
Button, A. C.....Saginaw
Cady, F. J.....Saginaw
Cameron, Allen K.....Saginaw
Campbell, L A.....Saginaw
Catizone, R. J.....Merrill
Chisena, Peter R.....M
Claytor, Archer A.....Saginaw
Cortopassi, Andre.....Saginaw
Cortopassi, V. E.....M
Cory, C. W.....M
Curts, James.....M
Durman, Donald.....Saginaw
Ely, C. W.....Saginaw
Ernst, Arthur R.....Saginaw
Eymer, Esther .....Saginaw
Fleschner, Thos. E.....Birch Run
Gage, David P.....Saginaw
Galsterer, E. C.....Saginaw
Gerber, Herbert.....M
Goman, Louis D.....Saginaw
Grigg, Arthur.....Saginaw
Grigg, Arthur P.....M
Hand, Eugene.....M
Harvie, L. C.....Saginaw
Helmkamp, H. C.....Saginaw
Hester, E. G.....M
Hill, Victor L.....Saginaw
Hohn, Fred J.....Saginaw
Howell, Don M.....Saginaw
Imerman, Harold M.....M
Jaenichen, R. .....Saginaw
James, J. W.....M
Jiroch, R. S.....Saginaw
Jordan, Leo A.....Saginaw
Keller, S. S.....Saginaw
Kemp, J. N.....Saginaw
Kempton, R. M.....Saginaw
Kerr, Wm.....M
Kirchgeorge, Clemens..Frankenmuth
Kleekamp, H.....Saginaw
Knott, Harriet A.....Saginaw
Kowals, F. V.....Saginaw
Lohr, O. W.....Saginaw
Longstreet, Martha L.....Saginaw
Luger, F. E.....M
Lurie, Robt.....M
Lyle, R. C.....Frankenmuth
MacKinnon, Edwin D.....Saginaw
MacMeekin, James W.....M
Martzowka, Wm. P.....Saginaw
Maurer, J.....Saginaw
Maurer, John A.....M
Mayne, Harold E.....Saginaw
McGregor, R.....Saginaw
McKinney, Alex R.....Saginaw
McLandress, Joshua A.....Saginaw
Markey, J. P.....Saginaw
Meyer, Henry J.....Saginaw
Mikan, V. Robt.....Saginaw
Moon, A. R.....Saginaw
Mudd, Richard D.....M
Murphy, Albert P.....Saginaw
Murray, Chas. R.....M
Novy, F. O.....Saginaw
O'Reilly, Wm. J.....(E)..Saginaw
Ostrander, Frank W.....Freeland
Phillips, Homer A.....M
Pietz, Frederick.....Saginaw
Pillsbury, Edward A...Frankenmuth
Poole, Frank.....Saginaw
Potvin, Clifford.....M
Richards, Ned W.....M
Richter, Harry J.....M
Ryan, M. D.....(E)..Saginaw
Ryan, R. S.....M
Sample, J. T.....Saginaw
Schaiberger, Elmer G.....Saginaw
Schneider, Alexander.....M
Sheldon, S.....M
Skowronski, Casimer A.....M
Slack, Walter K.....M
Stander, A. C.....M
Stewart, George W.....M
Stiller, A. F.....Saginaw
Thomas, Dale.....Saginaw
Tiedke, G. E.....M
Toshach, C. E.....Saginaw
Treshler, H. J.....Saginaw
Wallace, H. C.....M
Westlund, Norman.....Saginaw
Wilson, H. R.....Saginaw
Yntema, S.....M

St. Clair County

Armsbury, A. B.....Marine City
Atkinson, J. M.....Port Huron
Attridge, J. A.....Port Huron
Banting, K. C.....M
Battley, J. C. S.....Port Huron
Beck, Frank K.....Port Huron
Biggar, R. J.....M
Borden, C. L.....Port Huron
Boughner, W. H.....Algonac
Bovee, M. E.....Port Huron
Brush, Howard O.....Port Huron
Burke, Ralph M.....Port Huron
Burley, Jacob H.....Port Huron
Callery, A. L.....Port Huron
Campbell, R. H.....St. Clair
Carey, Lewis M.....Detroit
Clyne, B. C.....M
Cooper, Thomas H.....Port Huron
DeGurse, T. E.....Marine City
Derck, W. P.....Port Huron
Edwards, A. C.....Port Huron
Fraser, Robt. C.....Port Huron
Hall, W. E. B.....Port Huron
Heavenrich, Theo. F.....Port Huron
Holcomb, R. J.....Marine City
Kesl, Geo. Matthew.....Port Huron
LeGalley, K. B.....M
Licker, R. R.....M
Ludwig, F. E.....M
Martin, C. S.....Port Huron
McColl, D. J.....Port Huron
McColl, Neil J.....Port Huron
MacPherson, C. A.....St. Clair
Meredith, E. W.....Port Huron
Patterson, D. Webster...Port Huron
Pollock, Donald A.....Yale
Reynolds, Annie E.....Port Huron
Ryerson, W. W.....Port Huron
Schaefer, W. A.....Port Huron
Searles, Karl F.....Capac
Sites, E. C.....Port Huron
Thomas, C. F.....Port Huron
Treadgold, Douglas.....Port Huron
Ware, John R.....Port Huron
Wass, Henry C.....St. Clair
Waters, George.....Port Huron
Wellman, Joseph E.....Port Huron
Wight, Wm. G.....Yale
Witter, Gordon L.....M
Zemmer, A. L.....Port Huron

St. Joseph County

Berg, Lawrence A.....M
Brunson, A. E.....Colon
Corkill, C. C.....White Pigeon
Fiegel, S. A.....M
Hoekman, Aben.....M
Holm, Arvid G.....M
Kane, David M.....Sturgis
Miller, C. G.....Sturgis
Parrish, Marion F.....Sturgis
Pennington, H. C.....M
Porter, C. G.....Three Rivers
Raisch, Fred J.....M
Reed, Fred R.....Three Rivers
Rice, John W.....M
Shaw, G. D.....M
Sheldon, J. P.....M
Slote, L. K.....Constantine
Springer, R. A.....Centerville
Sweetland, G. J.....Constantine
Wilkerson, Nina C.....Sturgis
Zimont, R. D.....M

Sanilac County

Blanchard, E. W.....Deckerville
Ellis, N. J.....Croswell
Gift, W. A.....Marlette
Hart, R. K.....Croswell
Koch, D.....M
Learmont, H. H.....Croswell
McGunegle, K. T.....Sandusky
Norgaard, Hal V.....M
Seager, M. Cole.....Brown City
Tweedie, G. Evans.....Sandusky
Tweedie, S. Martin.....Sandusky
Webster, John C.....Marlette

Shiawassee County

Alexander, Reuben G....Laingsburg
Arnold, A. L.....Owosso
Arnold, A. L., Sr. (E).....Owosso
Backe, John C.....M
Brandel, J. M.....M
Brown, Richard J.....M
Buzzard, Walter Davenport.....M
Cramer, Geo. L. G. (E).....Owosso
Fillinger, W. B.....Ovid
Hoshal, Vern L.....Durand
Hume, Arthur M. (E).....Owosso
Hume, Harold A.....Owosso
Janci, Julius .....M
Kaufman, H. J.....M
Lanting, Helen E.....Owosso
Linden, V. E.....M
McKnight, E. R.....M
Parker, W. T.....Owosso
Pochert, R. C.....Owosso
Richards, C. J.....Durand
Shepherd, W. F.....M
Slagh, E. M.....M
Soule, Glen T.....Henderson
Watts, Fred A.....Owosso
Weinkauf, W. F.....Corunna
Weston, C. L.....Owosso
Wilcox, Anna L.....Owosso
Wilcox, C. M.....M

Tuscola County

Barbour, Harry A.....Mayville
Bates, George (E).....Kingston
Berman, Harry .....Millington
Cook, Raymond, R.....Akron
Dickerson, W. W.....Caro
Dixon, Robt. L.....Wahjamega
Donahue, H. Theron.....Cass City
Fisher, Robt. E.....M
Flett, Richard .....Millington
Fox, Denton B.....Wahjamega
Gugino, Frank J.....M
Hoffman, T. E.....M
Howlett, R. R.....M
Johnson, O. G.....Mayville
Kaven, G. H.....Unionville
MacRae, L. D.....Gagetown
Merrill, Elmer H.....Caro
Morris, Frank L.....Cass City
Rundell, Annie S.....Vassar
Ruskin, D. B.....Caro
Savage, Lloyd L.....Caro
Shoemaker, J. C.....Vassar
Spohn, U. G.....Fairgrove
Starmann, Bernard.....Cass City
Swanson, E. C.....Vassar
Vail, Harry F.....M
Von Renner, Otto.....Vassar

Van Buren County

Boothby, F. M.....Lawrence
Bope, Wm. P.....Decatur
Buckborough, M. W.....S. Haven
Diephuis, Bert .....M
French, Merle R.....Paw Paw
Gano, Avison .....M
Giddings, Ralph R.....M
Greenman, Newton H.....Decatur
Hall, E. J.....M
Hasty, Willis A.....M
Hoyt, W. F. .....(E) Paw Paw
Iseman, Joseph W.....M
Itzen, J. F.....South Haven
Jamieson, J. K.....Paw Paw
Laird, Emma .....Paw Paw
Lowe, Edwin G.....Bangor
Maxwell, J. Chas.....Paw Paw
McNabb, A. A.....Lawrence
Murphy, Norman D.....Bangor
Penoyar, C. L.....South Haven
Sayre, Phillip P.....South Haven
Spalding, R. .....Gobles
Steele, Arthur H.....Paw Paw
Ten Houten, Chas.....M
Terwilliger, Edwin .....M
Urist, Martin J.....South Haven
Williams, F. N.....Hartford
Young, Wm. R.....Lawton

Washtenaw County

Agate, George H.....M
Alexander, John .....Ann Arbor
Armstrong, Richard C.....M
Badgley, C. E.....Ann Arbor
Baer, Louis S.....M
Baker, David.....Ann Arbor
Barker, Paul S.....M
Barnes, Allan C.....M
Barnwell, John B.....Ann Arbor
Barr, Albert S.....Ann Arbor
Barss, Harold D.....Ypsilanti
Bassow, Paul H.....Ann Arbor
Bauer, Gerhard H.....M
Baugh, Richard H.....Ypsilanti
Beall, John G.....Ann Arbor
Beebe, Hugh M.....Ann Arbor
Bell, Margaret .....Ann Arbor
Belser, Walter .....Ann Arbor
Bethell, Frank H.....Ann Arbor
Boyer, Philip A.....Ann Arbor
Brace, Wm. M.....Ann Arbor
Breakey, J. F..... (R) Ann Arbor
Britton, H. B.....Ypsilanti
Brown, Phillip N.....Ypsilanti
Bruce, James D.....Ann Arbor
Bullington, Bert M.....M
Bulmer, Dan J.....M
Buscaglia, C. J.....M
Buxton, Robt W.....Ann Arbor
Camp, Carl D.....Ann Arbor
Clements, Glenn T.....Ann Arbor
Cody, Claude C.....Ann Arbor
Coller, Frederick A.....Ann Arbor
Congor, Kyril B.....M
Conn, Jerome W.....Ann Arbor
Cooper, Ralph R.....M
Coxon, A. Wm.....Ann Arbor
Crabtree, Peter .....M
Cummings, H. H.....Ann Arbor
Curtis, Arthur C.....Ann Arbor
Davis, Fenimore E.....M
Day, A. Jackson.....M
deAlvarez-Skinner, R. R.....M
DeJong, Russell .....Ann Arbor
DeTar, John S.....Milan
Dimitroff, Sim .....M
Dingman, Reed O.....Ann Arbor
Donaldson, S. W.....Ann Arbor
Dowman, Chas. E.....M
Duff, Ivan F.....M
Dunstone, H. C.....Yysilanti
Engelke, Otto K.....Ann Arbor
Everett, Meldon .....Ann Arbor
Failing, Joseph H..San Marino, Cal.
Falls, Harold F.....Ann Arbor
Farrior, J. Brown.....M
Field, Henry J.....Ann Arbor
Fitzgerald, Thomas D.....M
Fletcher, Donald B.....M
Forsythe, Warren E.....Ann Arbor
Foster, D. Bernard.....Ann Arbor
Fralick, F. Bruce.....Ann Arbor
Freyberg, Richard H.....Ann Arbor
Frye, Carl H.....Ann Arbor
Furstenberg, A. C.....Ann Arbor
Ganzhorn, Edwin C.....Ann Arbor
Gardiner, Sprague .....M
Gates, John L.....Ann Arbor
Gates, Neil A.....Ann Arbor
Green, Mervin E.....M
Green, Nelson W.....Detroit
Gulde, Andros .....Chelsea
Haas, Reynold L.....Ann Arbor
Hagerman, Geo. W.....M
Haight, Cameron .....Ann Arbor
Hammond, Geo. .....M
Hamond, W. W.....Plymouth
Handorf, H. H.....Northville
Hannum, M. R.....Milan
Harris, Bradley M.....M
Haynes, Harley A.....Ann Arbor
Healey, Claire E.....Ann Arbor
Henry, L. Dell.....Ann Arbor
High, Howard C.....M
Himler, Leonard E.....Ann Arbor
Hirschfield, Alex H.....M
Hodges, Fred J.....Ann Arbor
Holt, John F.....Ann Arbor
Howard, S. C.....Ann Arbor
Howell, Roger W.....Ann Arbor
Howes, H. A.....M
Hunt, Homer H.....M
Jay, Baird D.....M
Jimenez, Buenaventura ..Ann Arbor
Johnson, Lester J.....M
Johnson, Sture A. M.....Ann Arbor
Johnston, Franklin D.....Ann Arbor
Jordan, Paul H.....M
Juracsek, Valeria R.....Ann Arbor
Kahn, Edgar A.....M
Keller, Arthur P.....M
Kemper, J. W.....Ann Arbor
Kiehn, Clifford L.....M
Kleinschmidt, E. E.....
Chevy Chase, Md.
Kleinschmidt, Gladys .....
Chevy Chase, Md.
Klingman, Theophil ....Ann Arbor
Knoll, Leo .....Ann Arbor
LaFever, Sidney L.....Ann Arbor
Lane, Edwin C.....Ypsilanti
Lawther, John.....Portland, Ore.
Law, John L.....Ann Arbor
Levin, Manuel .....M
Lichty, Dorman E.....Ann Arbor
List, Carl F.....Ann Arbor
Lynn, Harold P.....Ypsilanti
Lyons, Richard H.....Ann Arbor
MacIntyre, Dugald S.....M
MacKaye, Lavina G.....Ann Arbor
Malcolm, Karl D.....Ann Arbor
Marshall, Mark .....Ann Arbor
Martin, Donald W.....Ypsilanti
Maxwell, J. H.....Ann Arbor
McCotter, Rollo E.....Ann Arbor
McEachern, Thomas H...Ann Arbor
Means, Myron G.....Ann Arbor
Metzger, Ida .....Ypsilanti
Milford, Albert F.....Ypsilanti
Miller, Harold .....M
Miller, Norman F.....Ann Arbor
Moore, Donald F.....M
Morrow, Grant .....Ann Arbor
Muehlig, George F.....Ann Arbor
Myers, Dean W.....Ann Arbor
Nesbit, Reed M.....Ann Arbor
Newton, Chas W.....Ann Arbor
Oliphant, L. W.....Ann Arbor
Palmer, Alger A.....M
Pannabecker, Chas. L....Ann Arbor
Parsons, Robt. Jerome...Ann Arbor
Patterson, Ralph M.....Ann Arbor
Peet, Max M.....Ann Arbor
Pillsbury, Chas. B.....Ypsilanti
Pollard, H. Marvin.....Ann Arbor
Potter, Marcia .....Ypsilanti
Power, Frank H.....M
Price, Helen F.....Ann Arbor
Prout, Gordon H.....Saline
Quirk, Edmund J.....Chelsea
Rague, Paul O.....M
Randolph, Theron G.....Ann Arbor
Raphael, Theophile .....Ann Arbor
Ratliff, Rigdon K.....Ann Arbor
Ransom, Henry K.....Ann Arbor
Reynolds, Stephen .....M
Riecker, H. H.....Ann Arbor
Riggs, Harold W.....Ann Arbor
Robb, David N.....Ypsilanti
Rosenbaum, Francis F....Ann Arbor
Ross, Howard .....Ann Arbor
Sacks, Wilma .....Ann Arbor
Salon, Dayton D.....M
Schumacker, W. E.....Ann Arbor
Scott, Robt. R.....M
Scott, Wm. C.....M
Scurry, M. M.....M
Seevers, M. H.....Ann Arbor
Seime, Reuben I.....Ann Arbor
Sink, Emory W.....Ann Arbor
Smalley, Marianna .....Ann Arbor
Smith, Joseph G.....M
Solis, Jeanne C.....(E) Ann Arbor
Stoddard, F. Jackson.....Ann Arbor
Sturgis, C. C.....Ann Arbor
Sundwall, John .....Ann Arbor
Teed, Reed W.....M
Thieme, E. Thurston.....M
Towsley, Harry A.....M
Trimby, Robt. H.....Ann Arbor
Valk, Wm. L.....M
Vander Slice, David.....Ann Arbor
Waggoner, R. W.....Ann Arbor
Waldron, Alexander M.....M
Wallace, J. B.....(R) Saline
Wanstrom, Ruth .....Ann Arbor
Washburne, Chas. L.....Ann Arbor
Watson, Ernest Hamilton.Ann Arbor
Weller, Carl V.....Ann Arbor
Wellman, Waldron W.....Ypsilanti
Wessinger, J. A.....(E) Ann Arbor
Wile, Udo J.....M
Williams, Howard R.....Ann Arbor
Williamson, F. B.....Ypsilanti
Wilson, Frank N.....Ann Arbor
Wisdom, Inez R.....Ann Arbor
Woods, J. J.....Ypsilanti
Worth, Melissa H.....Ypsilanti
Wright, W. J.....Ypsilanti
Wylie, Wm. C.....Dexter
Yoder, O. R.....Ypsilanti

Wayne County

Abbott, Wm. E.....Detroit
Aaron, Charles D. (E).....Detroit
Abrams, Harry M.....Detroit
Abramson, Max .....Detroit
Abruzzo, Anthony M.....M
Adams, James R.....Dearborn
Adelson, Sidney L.....M
Adler, Sidney .....M
Agins, Jacob .....Detroit
Agnelly, Edward J.....Detroit
Agnew, George H.....Detroit
Alderman, R. F.....Detroit
Aldrich, E. Gordon.....Detroit
Aldrich, Napier .....M
Allen, John V.....Lincoln Park
Alles, Russell W.....Detroit
Allison, Frank B.....Detroit
Allison, Herbert C.....
Grosse Pte. Farms
Altman, Raphael .....Detroit
Altshuler, Abraham M.....Detroit
Altshuler, Ira M.....Detroit
Altshuler, Samuel S.....M
Amberg, Emil (E).....Detroit
Amos, Thomas G.....Detroit
Anderson, Bruce .....Detroit
Anderson, Gordon H.....M
Anderson, J. O.....Detroit
Anderson, Walter L.....M
Anderson, Walter T.....Detroit
Andries, Joseph H.....Detroit
Andries, Raymond C.....Detroit
Ankley, J. W.....Detroit
Annessa, Dommenico M.....Detroit
Anslow, E. Robt.....Detroit
Appel, P. R.....Detroit
Appelman, H. B.....Detroit
Arehart, Burke W.....M
Armstrong, Arthur G.....Detroit
Arnold, Effie .....Detroit
Aronstam, Noah E.....Detroit
Arrington, Robyn J.....Detroit
Ascher, Meyer S.....M
Ashe, Stilson R.....Detroit
★Ashley, James B.....
Ashley, L. Byron.....M
Ashton, F. B.....Highland Park
Asselin, J. L.....Detroit
Asselin, Regis F.....M
Athay, Roland M.....Detroit
Atchison, Russell M.....Northville
Atler, Lawrence R.....Detroit
Atler, Leroy L.....M
Aubel, M. E.....Detroit
August, Harry E.....M
Axelrod, Stanley H.....Detroit
Axelson, A. U.....Detroit

Babcock, Kenneth B.....M
Babcock, L. K.....Detroit
Babcock, Myra E.....Detroit
Babcock, W. W.....Detroit
Bach, Walter F.....Detroit
Bachman, Morris E.....Detroit
Bacon, Vinton A.....Detroit
Baer, George J.....Detroit
Baer, Raymond B.....Detroit
Baeff, Michael A.....Detroit
Bagley, Harry E.....M
Bailey, Carl C.....M
Bailey, Don A.....Detroit
Bailey, Louis J.....Detroit
Baker, Clarence .....Detroit
Balaga, F. T.....Detroit
Balcerski, Matthew A.....Detroit
Ballard, Charles S.....Detroit
Balser, Chas. W.....Detroit
Baltz, James I.....Detroit
Baranowsi, A. W.....Detroit
Barone, Charles J....Highland Park
Barrett, Wyman D.....Detroit
Barron, Wm. H.....Detroit
Bartemeier, Leo H.....Detroit
Barton, J. R.....Detroit
Bates, Gaylord .....M
Bates, Morton .....Wayne
Bauer, Benedict J.....Detroit
Bauer, A. Robt.....Detroit
Bauer, Lester Eugene.....M
Baumer, Moe .....M
Baumgarten, Elden C.....Detroit
Bayles, John G.....Detroit
Beach, Watson .....Detroit
Beam, A. Duane .....M
Beaton, Colin .....M
Beattie, Robert .....Detroit
Beaver, Donald C.....Detroit
Beck, Eva F.....Eloise
Becker, Abraham .....M
Becker, Joseph W.....Detroit
Becklein, C. L.....Detroit
Beckwitt, M. C.....M
Bedell, A. .....Detroit
Beer, Joseph F.....M
Beeuwkes, L. E.....M
Begle, H. L.....Detroit
Behn, Claud W.....Detroit
Beigler, Sydney K.....Detroit
Beitman, Max R.....M
Belanger, Ernest E.....M
Belanger, Henry.....Detroit
Belanger, Wm. George.....M
Belknap, Warren F.....M
Bell, J. Kenner.....Detroit
Bell, Wm. M.....Detroit
Bennett, Germany E.....Detroit
Bennett, Harry B.....Detroit
Bennett, Zina B.....Detroit
Benson, C. D.....M
Benson, Davis A.....M
Benson, Virginia.....Detroit
Bentley, Frederick E.....Plymouth
Bentley, Neil I.....Detroit
Berent, Morris S.....Detroit
Beresh, Louis.....M
Berge, Clarence A.....Detroit
Bergman, Murray Stewart....Detroit
Bergo, Howard L.....M
Berke, Sydney S.....Detroit
Berkey, Wm. E.....Detroit
Berlien, Ivan C.....M
Berman, Lawrence.....Detroit
Berman, Robert.....Detroit
Berman, Sidney.....M
Bernard, Walter G.....Detroit
Bernbaum, Bernard.....Detroit
Bernstein, Albert E.....Detroit
Bernstein, Samuel S.....M
Berry, Joseph E.....Detroit
Besancon, J. H.....M
Best, T. H. Edward.....Detroit
Bicknell, Edgar A.....M
Bicknell, Frank B.....M
Bicknell, Nathan J.....Detroit
Biddle, Andrew P.....(E)..Detroit
Birch, John R.....M
Birkelo, Carl C.....Detroit
Bittker, I. Irving.....Detroit
Black, Perry S.....Detroit
Blackford, Roger W.....Detroit
Blain, Alexander W.....Detroit
Blain, James H., Jr.....M
Blaine, Max.....Detroit
Blair, K. E.....Detroit
Blashill, James B.....M
Blau, Morris H.....Detroit
Bleier, Joseph.....Detroit
Bloch, Abraham.....Detroit
Blodgett, Wm. E.....Detroit
Blodgett, Wm. H.....M
Bloom, Arthur R.....Detroit
Bloomer, Earl.....Dearborn
Blumenthal, Franz L.....Detroit
Boccaccio, John.....M
Boccia, James J.....M
Boddie, Arthur W.....Detroit
Boddie, Lewis Franklin.....Detroit
Boehm, John D.....Detroit
Boell, Arthur F.....Detroit
Bogusz, Ladislaus.....Eloise
Bohn, Stephen.....M
Boileau, Thornton I.....M
Boles, A. E.....M
Bookmyer, R. H.....Detroit
Bookstein, Abraham.....M
Boutrous, Thomas A.....Detroit
Bovill, Edwin G.....M
Bower, Franklin T.....Detroit
Bowers, Leo J.....Detroit
Bowman, Frank.....Detroit
Boyd, John H.....Trenton
Brachman, D. S.....Detroit
Bracken, Andrew H.....Dearborn
Bradford, Henry.....M
Bradley, George.....Detroit
Bradshaw, Wm. H.....Detroit
Braitman, Louis.....Detroit
Braley, W. N.....Detroit
Bramigk, F. W.....Detroit
Brancheau, L. T.....M
Brando, Russell G.....Detroit
Brandt, Edward L.....Detroit
Braun, Lionel.....M
Brengle, Deane R.....Detroit
Breon, Guy L.....Detroit
Briegel, Walter A.....Detroit
Brines, O. A.....M
Bringard, Elmer L.....M
Brisbois, Harold J.....Plymouth
Brodersen, Harvey S....River Rouge
Bromme, William.....M
Brooks, A. L.....Detroit
Brooks, Clark D.....Detroit
Brooks, Charles W.....M
Brooks, Nathan.....M
Brosius, William L.....Detroit
Broudo, Philip H.....Detroit
Brough, Glen A.....M
Brown, A. O.....Detroit
Brown, Carleton F.....M
Brown, Francis.....Detroit
Brown, Gordon T.....Detroit
Brown, Harvey F.....Detroit
Brown, Henry S.....Detroit
Brown, John R.....M
Brown, Stanley H.....Detroit
Brown, Thomas A.....Detroit
Brownell, Paul G.....M
Bruehl, Richard A.....Detroit
Brunk, Andrew S.....Detroit
Brunk, Clifford F.....Detroit
Brunke, B. B.....Detroit
Brush, Brock Edwin.....Detroit
Bryce, John D.....M
Buchanan, W. Paul.....Detroit
Buchner, Harold W.....M
Buck, John D.....Detroit
Budson, Daniel .....Detroit
Buell, Charles E., Jr.....Detroit
Buell, Martin.....Dearborn
Buesser, Frederick G.....Detroit
Buller, H. L.....Detroit
Burgess, Chas. M.....Detroit
Burgess, Jay M.....Detroit
Burns, Robert T.....Detroit
Burnham, David C.....Detroit
Burnstine, Julius Y.....Detroit
Burnstine, Perry P.....M
Burr, George C.....Detroit
Burr, H. Leonard.....Grosse Pointe
Burrows, Howard A.....Dearborn
Burstein, Harry S.....Detroit
Burstein, I. Marvin.....Detroit
Burstein, Morris M.....Detroit
Burton, D. T.....Detroit
Bush, Glendon .....M
Bush, Lowell M.....Detroit
Buss, John A.....Detroit
Butler, Harry J.....Detroit
Butler, L. H.....Detroit
Butler, Volney N.....Detroit
Butterworth, Herman..Lincoln Park
Buttrum, Edward J.....Detroit
Byers, Dudley W.....Detroit
Byington, Garner M.....Detroit
Cadieux, Henry W.....Detroit
Caldwell, J. Ewart.....M
Caldwell, George L.....Detroit
Calkins, H. N.....M
Callaghan, T. T.....M
Campau, George H.....Detroit
Campbell, Duncan.....Detroit
Campbell, Duncan A.....Detroit
Campbell, Malcolm D.....Detroit
Campbell, Mary B.....Detroit
Candler, Clarence L.....Detroit
Canter, Allie L.....Detroit
Canter, G. E.....Detroit
Caplan, Leslie .....M
Caputo, Joseph M.....M
Caraway, Jas. E.....M
Carbone, Louis A.....Detroit
Carey, Cornelius .....Detroit
Carleton, L. H.....Detroit
Carlucci, Peter F.....Detroit
Carmichael, E. K.....Detroit
Carnes, Harry E.....M
Carp, Joseph .....M
Carpenter, C. H.....Detroit
Carpenter, C. J.....Detroit
Carpenter, Glenn B.....Detroit
Carr, J. G.....Detroit
Carroll, E. H.....Detroit
Carroll, Lona B.....Detroit
Carson, Herman J.....Detroit
Carstens, Henry R.....M
Carter, John M.....Detroit
Carter, L. F.....Detroit
Cassidy, Wm. J.....Detroit
Castrop, C. W.....Dearborn
Cathcart, Edward .....M
Catherwood, Albert E.....Detroit
Caton, Dorothy .....Detroit
Caughey, Edgar H.....M
Cavell, Roscoe Wm.....M
Cetlinski, C. A.....Hamtramck
Chall, Henry G.....Detroit

★Died in Military Service.

Chalat, Jacob H.....Detroit
Chance, J. H.....Detroit
Chapman, Aaron L.....Detroit
Chapman, Everett L.....Detroit
Chapman, Paul T.....Detroit
Chapnick, H. A.....M
Chase, Clyde H.....Detroit
Chase, Harold F.....Detroit
Chatel, Arthur N.....Detroit
Chenik, Ferdinand .....Detroit
Chester, W.....Detroit
Chesluk, H. M.....M
Childs, George Millard.....M
Chipman, W. A.....Detroit
Chittenden, Geo. E.....M
Chittick, Wm. R. (E).....
San Diego, Cal.
Christensen, C. A.....Dearborn
Christopher, James G.....Detroit
Chrouch, L. A.....Detroit
Cioffari, Mario S.....Detroit
Ciprian, Joseph E.....Detroit
Clark, Benjamin W.....M
Clark, C. M.....Detroit
Clark, Donald K.....
San Francisco, Cal.
Clark, Donald V.....Detroit
Clark, George E. (E).....Detroit
Clark, Harold E.....Detroit
Clark, Harry G.....Detroit
Clark, Harry L.....Detroit
Clark, Ronald E.....Detroit
Clarke, Emilie Arnold.....Detroit
Clarke, Geo. L.....Detroit
Clarke, Niles A.....M
Clarke, Norman E.....Detroit
Clayton, Paul A.....Wayne
Clifford, C. H.....Detroit
Clifford, John E.....Detroit
Clifford, Thos. P.....Detroit
Clippert, J. C. (E).....Grosse Ile
Coan, Glenn L.....Wyandotte
Coates, Carl Amos.....Dearborn
Cobane, John H.....Detroit
Cochrane, Edgar G.....Detroit
Cohn, Daniel E.....M
Cohoe, Don A.....Detroit
Cole, Fred H.....Detroit
Cole, James E.....Detroit
Cole, Wyman C. C.....M
Coleman, Margarete W.....Detroit
Coleman, Wm. G.....Redford
Coll, Howard R.....Detroit
Collings, M. Raymond.....Detroit
Collins, Arthur D.....M
Collins, Edmund F.....Detroit
Collins, James D.....Detroit
Colvin, Leslie T.....Detroit
Colyer, Raymond G.....Detroit
Comstock, Lawrence .....Trenton
Connelly, Basil L.....Detroit
Connelly, Richard C.....Detroit
Connelly, Frank .....Detroit
Connolly, John P.....Detroit
Conley, L. C. M.....Detroit
Connors, J. J.....Detroit
Conrad, E. R.....Detroit
Constable, Canute G.....Detroit
Cooksey, Warren B.....Detroit
Cook, James C.....M
Coolidge, M. Belle..Grosse Pt. Park
Cooper, E. L.....Detroit
Cooper, James B.....Detroit
Corbeille, Catherine .....Detroit
Coseglia, Robt. P.....Detroit
Costello, Russell T.....Detroit
Cotruro, L. D.....Detroit
Cotton, S. O.....Detroit
Coucke, Henry O.....M
Coulter, Wm. J.....Detroit
Cowan, Wilfrid .....Detroit
Cowen, Leon B.....Detroit
Coyne, Douglas R.....Detroit
Craig, Henry R.....Eloise
Crane, Langdon T.....Detroit
Cree, Walter J. (E).....
Palm Beach, Fla.
Crews, Thomas H.....Detroit
Croll, L. J.....M
Cross, Harold E.....Detroit
Crossen, Henry F.....Detroit
Croushore, J. E.....M
Cruikshank, Alexander .....Detroit
Culp, Ormond .....M
Curry, F. S.....Detroit
Curtis, Frank E.....Detroit
Cushing, Russell G.....Detroit
Cushman, H. P.....Detroit
Dale, Esther .....Detroit
Dana, Harold M.....M
Danforth, J. C.....Detroit
Danforth, M. E.....Detroit
Daniels, L. E.....Detroit
Darling, Milton A.....Detroit
Darpin, Peter H.....Detroit
Davidson, Harry O.....M
Davies, Thos. S.....Grosse Pte.
Davies, Windsor S.....M
Davis, Egbert F.....Detroit
Davis, George H.....M
Davis, Lindon Lee.....M
Dawson, F. E.....Detroit
Dawson, W. A.....Inkster
Day, J. Claude.....M
Defever, Cyril R.....M
Defnet, Wm. A.....Detroit
DeGroat, Albert .....M
Delbert, Stewart G.....M
Demaray, John F.....Detroit
Dempster, James H.....Detroit
DeNike, A. James.....Detroit
Denis, George M.....Detroit
Denison, Louis L.....Detroit
DePonio, Sylvester A.....Detroit
Derby, Arthur P.....Detroit
Derleth, Paul E.....M
DeSpelder, Ray E.....Detroit
DeTomasi, Rome Q.....Detroit
Dibble, Harry F.....Detroit
Dickman, Harry M.....M
Dickson, D. R.....Detroit
Diebel, Nelson W.....Detroit
Diebel, Wm. H.....Detroit
Dietzel, H. O.....Detroit
Dill, Hugh L.....Detroit
Dill, J. Lewis.....Detroit
DiLoreto, Panfilo Camillo.....M
Dittmer, Edwin.....Detroit
Dixon, Fred W.....M
Dixon, Ray S.....Detroit
Dodds, John C.....Detroit
Dodenhoff, C. F.....Detroit
Doerr, Louis E.....M
Dolega, Stanley F.....M
Dolman, E. Nesbitt.....Detroit
Domzalski, C. A.....Detroit
Donald, Douglas .....M
Donald, Wm. M. (E).....Detroit
Donovan, Daniel R., Jr.....Detroit
Dorsey, John M.....Detroit
Doty, Chester A.....Detroit
Doub, Howard P.....Detroit
Douglas, Bruce H.....Detroit
Douglas, Clare L.....M
Dovitz, Benj. W.....Detroit
Dow, Roy E...Carlisle Barracks, Pa.
Dowdle, Edward .....Detroit
Dowling, H. E.....M
Downer, Ira G.....Detroit
Doyle, Geo. H.....Detroit
Drake, Ellet H.....M
Drake, James J.....Detroit
Draves, Edward F.....Detroit
Drews, Robt. S.....Detroit
Drinkhaus, H. I.....Detroit
Droock, Victor .....Detroit
Dubin, Joseph J.....Detroit
Dubnove, Aaron .....Detroit
Dubois, Paul W.....Detroit
Dubpernell, Karl .....Detroit
Dubpernell, Martin S.....Detroit
Ducey, Edward F.....M
Dudek, John J.....Wyandotte
Duffy, Edward A.....Detroit
Dundas, E. M.....Detroit
Dunlap, Henry A.....Detroit
Dunn, Cornelius E.....Detroit
Durocher, Edmund J.....Ecorse
Durocher, Normand E.....M
Dutchess, Charles E.....Detroit
Dwaihy, Paul .....Detroit
Dwyer, Francis.....M
Dysarz, T. T.....Detroit
Dziuba, John J.....M
Eades, Charles C.....M
Eakins, Frederick J.....Dearborn
Eaton, Crosby D.....Detroit
Edgar, Russell G.....Detroit
Eder, Joseph R.....M
Eder, Samuel J.....Detroit
Edgar, Irving I.....Detroit
Edmonds, W. N.....Detroit
Edwards, Gilbert L.....Detroit
Edwards, J. W.....Detroit
Eisman, Clarence H.....Detroit
Elliott, Wm. G.....Detroit
Ellis, Seth W.....M
Elvidge, Robt. J.....Detroit
Emmert, H. C.....Detroit
Engle, Earl H.....M
Ensign, Dwight C.....Detroit
Ensing, Osborn .....Detroit
Epstein, S. G.....M
Erickson, Milton H.....Eloise
Erkfitz, Arthur W.....Detroit
Eschbach, Jos. W.....M
Estabrook, Bert U.....Detroit
Ettinger, Clayton J.....Detroit
Evans, Jos. M.....Detroit
Evans, Leland S.....Redford
Evans, Wm. A., Jr.....M
Ewing, C. H.....M
Fair, B. B.....Detroit
Falick, Mordecai L.....M
Falk, I. E.....Detroit
Fallis, L. S.....Detroit
Fandrich, Theodore .....M
Farbman, Aaron A.....Detroit
Farbman, Simon S.....Detroit
Farney, Jacob P.....Detroit
Fauman, David H.....Detroit
Faunce, Sherman P.....Detroit
Fay, George E.....Detroit
Felcyn, W. Geo.....Detroit
Feldstein, Martin Z.....M
Fellers, Ray L.....Detroit
Fellman, Abraham R.....Detroit
Fenech, Harold B.....M
Fenner, Wm. A.....Detroit
Fenton, E. H.....Detroit
Fenton, Meryl M.....M
Fenton, Russell F.....Detroit
Fenton, Stanley C.....Detroit
Ferguson, Franklin F.....M
Ferrera, Louis V.....M
Ferrara, Virginia M.....Detroit
Fettig, Carl A.....Detroit
Field, G. S. (E).....Detroit
Finch, Alvis D.....Detroit
Fine, Edward .....Detroit
Fischer, Frederick J.....M
Fischer, Edward F.....Dearborn
Fisher, Geo. S.....M
Fisher, O. O.....Detroit
Fisher, R. L.....Detroit
Fitzgerald, E. W.....M
Fitzgerald, James M.....M
Flaherty, H. J.....Detroit
Flaherty, N. W.....M
Flaherty, S. A.....Detroit
Fleming, L. N.....Detroit
Flora, Wm. R.....M
Flower, J. A.....Detroit
Fogt, H. E.....Detroit
Fogt, Robt. G.....Detroit
Foley, Hugh S.....Dearborn
Font, Anthony J.....Detroit
Foote, James A.....Lincoln Park
Ford, F. A.....Detroit
Ford, Geo. A.....Detroit
Ford, Sylvester .....M
Ford, Walter D.....Detroit
Fordell, F. S.....Detroit
Forrester, Alex W.....Detroit
Forsythe, John R.....M
Foster, E. Bruce.....M
Foster, Daniel P.....Detroit
Foster, Linus J.....Detroit
Foster, Owen C.....Detroit
Foster, Wm. L.....Detroit
Foster, W. M.....Detroit
Fox, Morris E.....M
Fraiberg, Paul L.....Detroit
Franjac, M. J.....Dearborn
Franzen, Nils A.....Detroit
Fraser, E. E.....Detroit
Fraser, Harvey E.....M
Fraser, Herman F.....Detroit
Frazer, Mary Margaret.....Detroit
Freedman, John .....M
Freedman, Milton .....Detroit
Freeman, D. K.....Detroit
Freeman, Mabel .....Detroit
Freeman, Thelma .....Detroit
Freese, John A.....Detroit
Fremont, Joseph C.....M
Fried, Bernard H.....M
Friedlaender, Alex S.....Detroit
Friedman, David .....Detroit
Friedman, I. H.....Detroit
Frink, Norman W.....Detroit
Frost, Lyle .....Detroit
Frostic, Wm. D.....M
Frothingham, Geo. E. (E)...Detroit
Fuerbringer, Ralph O.....Detroit
Fullenwider, Allan C.....Detroit
Fuller, Hugh M.....M
Gaba, Howard .....M
Gabe, Sigmund .....M
Gaberman, David B.....Detroit
Gaffney, J. Mitchell.....Detroit

Galantowicz, H. C.....Detroit
Galdonyi, Laslo .....Detroit
Galdonyi, Nicholas .....Detroit
Galerneau, D. B.....Center Line
Gamble, Parker B.....Detroit
Gannan, Arthur M.....Detroit
Ganschow, John H.....Detroit
Gariepy, L. J.....Detroit
Garner, Howard B. (E).....Detroit
Gaston, Herbert B.....M
Gates, Nathaniel H.....Detroit
Gaynor, Alex .....Detroit
Gehring, Harold W.....Detroit
Gehrke, August E.....Detroit
Geib, Ledru O.....Detroit
Geib, Wayne A.....M
Geiter, Clyde W.....Detroit
Geitz, Wm. A.....Detroit
Gellert, I. S.....Detroit
Gemeroy, J. C.....Detroit
George, A. W.....Detroit
Gerondale, E. J.....Detroit
Gibson, James C. (E).....Detroit
Gigante, Nicola .....Detroit
Gignac, Arthur L.....Detroit
Gilbert, Harold R.....Wyandotte
Gilbert, Roy S.....Detroit
Gillman, R. W. (E).....Detroit
Gingold, Samuel M.....M
Gingrich, Wayne A.....M
Ginsberg, Harold I.....M
Gitlin, Charles .....M
Gittins, Perry C.....Detroit
Glasgow, Gordon K.....Detroit
Glassman, Samuel .....Detroit
Glazer, Walter S.....Detroit
Gleason, John R.....Detroit
Glees, J. L.....Grosse Pte. Farms
Glemet, Raymond B.....Detroit
Glickman, L. Grant.....M
Glowaki, B. F.....Detroit
Gmeiner, Clarence C.....Detroit
Goerke, Elmer A.....Romulus
Goetz, Angus G.....M
Goins, Wm. F.....Detroit
Goldberg, Arthur .....Detroit
Goldberg, Harry H.....Detroit
Goldberg, Nathan H.....Detroit
Goldin, M. I.....M
Goldman, Perry .....M
Goldsmith, J. D.....Detroit
Goldstone, R. R.....Detroit
Gollman, Maurice D.....M
Gonne, Wm. S.....Detroit
Good, Wm. H.....M
Goodrich, B. E.....M
Bordon, Wm. H.....M
★Goerelick, Harry S.....
Goins, Wm. F.....Detroit
Gorelick, Martin J.....M
Gorning, Raymond P.....Detroit
Gottschalk, Fred W.....Detroit
Gould, S. Emanuel.....Eloise
Goux, Raymond S.....Detroit
Grace, Joseph M.....Eloise
Graham, Julius A.....Detroit
Grain, Gerald O.....Detroit
Grajewski, Leo F.....Detroit
Gramley, Wm. .....Detroit
Granger, Francis L.....Detroit
Grant, Heman E.....Detroit
Gratton, Henri L.....Detroit
Gratzek, Frank R.....Detroit
Gravelle, L. J.....Detroit
Green, Ellis R.....Detroit
Green, Lewis .....Detroit
Green, Louis M.....M
Green, Simpson W.....Detroit
Green, Sydney H.....M
Greenberg, Julius J.....M
Greenberg, Morris Z.....M
Greene, John B.....Detroit
Greenidge, Robt. .....Detroit
Greenlee, Wm. Tate.....Detroit
Greiner, Bert A.....Detroit
Grekin, Joseph .....Detroit
Grekin, Samuel L.....Detroit
Griffith, Arthur J.....Detroit
Grillo, S. Phillip.....Belleville
Grimaldi, G. J.....M
Grob, Otto .....Detroit
Gronow, A. A.....Detroit
Grossman, Sol. .....M
Gruber, T. K.....Eloise
Gruhzit, Oswald M.....
Grosse Pte. Shores
Guimaraes, A. S.....Dearborn
Gurdjian, E. S.....Detroit
Gruman, Ben G.....M

★Died in Military Service.

Gutow, Benj. R.....M
Haefele, Leslie P.....Garden City
Hale, Arthur S.....Detroit
Hall, Arche C.....Detroit
Hall, E. Walter.....Detroit
Hall, Ralph E.....Detroit
Hall, Robt. J.....Detroit
Haluska, Jos. A.....Detroit
H'Amada, Norman K.....Detroit
Hamburger, A. C.....M
Hamil, Brenton M.....Detroit
Hamilton, Norman C.....Detroit
Hamilton, Stewart .....Detroit
Hamilton, Wm. .....Detroit
Hamilton, Wm. F.....Detroit
Hammer, Charles A.....Detroit
Hammer, Edwin J.....Detroit
Hammer, Howard J.....M
Hammond, A. E.....Detroit
Hammond, James L.....Inkster
Hanna, Carl .....M
Hanna, E. Howard.....Detroit
Hanna, Samuel C.....Detroit
Hansen, Frederick E.....Detroit
Hanser, Joshua .....Detroit
Hanson, Frederick N.....M
Harelik, E. W.....Detroit
Hardstaff, R. John.....Detroit
Hardy, George C.....Detroit
Harley, Louis M.....Detroit
Harm, W. B.....Detroit
Harper, Jesse T.....M
Harrell, Voss .....Detroit
Harris, Harold H.....M
Harris, Ivor David.....Detroit
Harris, Landy E.....Detroit
Harrison, Wesley .....Detroit
Hart, Charles E.....M
Hart, J. Clarence.....M
Hartgraves, Hallie .....Detroit
Hartman, F. W.....Detroit
Hartmann, W. B.....Detroit
Hartzell, John B.....M
Hasley, Clyde K.....Detroit
Hasley, Daniel E.....Detroit
Hastings, Orville J.....Detroit
Hause, Glen E.....M
Hauser, I. Jerome.....M
Hauser, John E.....Detroit
Havers, Howard .....Detroit
Hawken, Wm. C.....Detroit
Hawkins, James W.....Detroit
Hayes, Joseph D.....Detroit
Heath, Leonard P.....M
Heath, Parker .....Detroit
Heavner, L. E.....M
Hedges, Frank W.....Detroit
Hedrick, Donald W.....Detroit
Heenan, T. H.....Detroit
Heideman, Louis.....M
Heldt, Thomas J.....Detroit
Heller, C. George.....Detroit
Hendelman, Manuel H.....Detroit
Henderson, A. B.....M
Henderson, Harold .....Detroit
Henderson, J. L.....Detroit
Henderson, Leslie T.....Detroit
Henderson, Wm. E.....Detroit
Henderson, Wm. W.....M
Henig, Fred .....M
Henrich, L. E.....Detroit
Herkimer, Dan R.....M
Herrold, Rose E.....Detroit
Herschelmann, Roy F.....M
Hershey, Lynn N.....Detroit
Hewitt, Leland V.....Detroit
Hewitt, Robt. S.....M
Hayner, Stanley A.....Detroit
Hickey, Joseph .....Detroit
Higbee, Arthur L.....Detroit
Hildebrant, Hugh R.....Detroit
Hileman, Lee .....Ecorse
Hillenbrand, Alfred E.....M
Hiller, Glenn I.....Detroit
Hilton, Wm. E.....Detroit
Hinko, Edward N.....Eloise
Hipp, Wm. .....Detroit
Hirshfeld, John W.....Detroit
Hirschman, L. J.....Detroit
Hochman, Morton M.....Detroit
Hodges, Roy W.....Detroit
Hodgkinson, C. P.....M
Hodoski, Frank J.....Detroit
Hoenig, Andrew L.....Detroit
Hoffman, E. S.....Detroit
Hoffman, Henry A.....M
Hoffman, Martin H.....Detroit
Holcomb, August A.....Northville
Hollander, A. J.....Detroit
Hollis, Henry B.....Detroit
Holman, Herbert H.....M

Holmes, A. W.....Detroit
Holt, Henry T.....Detroit
Holstein, A. P.....M
Hohhart, Fred L.....Detroit
Honor, Wm. H.....Wyandotte
Hooker, Donald H.....M
Hookey, J. A.....M
Hooper, Norman L.....Detroit
Hoopes, Benj. F.....M
Hoops, George B.....Detroit
Hopkins, J. E.....Detroit
Horan, Thomas .....M
Horkins, Harold A.....Detroit
Horny, Hugo .....M
Horton, Reece H.....Detroit
Horvath, Louis O.....Detroit
Horwitz, John B.....M
Host, Lawrence N.....Detroit
Hotchkiss, Loris M.....Farmington
Howard, Austin Z.....Detroit
Howard, Philip J.....Detroit
Howell, Bert F.....Detroit
Howes, Willard B.....Detroit
Howlett, Howard T.....Detroit
Hromadko, Louis.....Detroit
Hubbard, John P.....Detroit
Hubbard, Ralph G.....Detroit
Hudson, A. Willis.....Detroit
Hudson, J. Stewart.....Grosse Pte.
Hudson, Wm. A.....Detroit
Huegli, Wilfrid A.....M
Huff, Reginald G.....Wayne
Hughes, Ray W.....Detroit
Hull, L. W.....Detroit
Hunt, T. H.....Detroit
Hunt, Verne G.....Detroit
Hunter, C. M.....Detroit
Hunter, Elmer N.....Detroit
Husband, Chas. W.....Detroit
Hyatt, Jarvis M.....M
Hyde, F. W.....Detroit
Iacobell, Peter H.....M
Ignatius, A. A.....Detroit
Ihle, Lyman E.....M
Insley, Stanley W.....Detroit
Irvin, Earle Albert.....Detroit
Irwin, W. A.....Detroit
Israel, Barney B.....M
Isaacs, Joseph C.....Detroit
Isaacson, Arthur .....Detroit
Ivkovich, Peter .....M
Jacobson, Samuel D.....Eloise
Jacoby, Myron D.....Detroit
Jaeger, Grove A.....Detroit
Jaeger, Julius P.....Detroit
Jaekel, C. N.....Detroit
Jaffar, Donald J.....Detroit
Jaffe, J. L.....Detroit
Jaffe, Jacob .....Detroit
Jaffe, Louis.....M
Janicki, Natalia J.....Eloise
Jahsman, Wm. E.....Detroit
James, L. Mae.....Detroit
James, Richard G.....Detroit
Jamieson, Robt. C.....Detroit
Jamieson, Thomas J....Lincoln Park
Jarre, Hans A.....Detroit
Jarzynka, Frank J.....Dearborn
Jasion, Lawrence J.....M
Jend, Wm. J.....Detroit
Jenkins, E. A.....M
Jenne, Byron H.....Detroit
Jennings, Alpheus F.....Detroit
Jennings, Robt. M.....M
Jentgen, Chas. J.....Detroit
Jentgen, L. G.....Detroit
Jewell, F. C.....Detroit
Jocz, Marion W.....Detroit
Jodar, E. O.....Detroit
John, Hubert R.....Detroit
Johnson, Homer L.....Detroit
Johnson, Neumon .....Detroit
Johnson, Ralph A.....Detroit
Johnson, R. M.....Detroit
Johnson, V. P.....Detroit
Johnson, V. C.....Detroit
Johnston, C. G.....M
Johnston, Everett V.....Detroit
Johnston, J. A.....Detroit
Johnston, John L.....Detroit
Johnston, Wm. E.....Detroit
Johnstone, B. I.....Detroit
Joinville, E. V.....Detroit
Jones, Arthur J.....Detroit
Jones, Adrian R.....Detroit
Jones, Edna M.....Detroit
Jones, H. C.....M
Jones, L. Faunt.....Detroit
Jones, Roy D.....Detroit
Jonikaitis, Joseph J.....Detroit

Joyce, Stanley J.....M
Judd, C. Hollister.....Detroit
Juliar, Benj. .....M
Jurow, Harry N.....Detroit

Kahn, Wm. W.....Detroit
Kallet, Herbert I.....Detroit
Kallman, R. Robt.....M
Kaminski, L. R.....Detroit
Kaminski, Zeno L.....Detroit
Kamperman, George A.....Detroit
Kanter, Herman .....M
Kapetansky, A. J.....Detroit
Kapetansky, N. J.....Detroit
Kaplita, Walter A.....M
Karr, Herbert S.....Detroit
Kasaback, V. Y.....Detroit
Kass, J. B.....Detroit
Kates, Simon C.....Detroit
Katzman, I. S.....Detroit
Kauffman, Wm. .....M
Kaump, Donald H.....Detroit
Kay, Edward W.....Hamtramck
Kay, Harry H.....M
Kazdan, Louis .....M
Kazdan, Morris A.....M
Keane, Wm. E.....Detroit
Kearns, Hubert J.....Detroit
Keating, Thomas F.....Detroit
Keene, Clifford H.....M
Kehoe, Henry J.....E. Detroit
Kelly, Edward W.....Detroit
Kemler, W. J.....Ecorse
Kennary, James M.....Detroit
Kennedy, Chas. S.....Detroit
Kennedy, L. F.....Detroit
Kennedy, Robt. B.....Detroit
Kenning, John C.....
Beverly Hills, Cal.
Kenyon, Fanny H.....Detroit
Kern, W. H.....Garden City
Kernkamp, Ralph .....Detroit
Kernick, Melvin O.....M
Kersten, Armand G.....Detroit
Kersten, Werner.....Detroit
Keshishian, Sarkis K.....Detroit
Keyes, Eugene .....Dearborn
Keyes, John W.....M
Kibzey, Ambrose T.....Detroit
Kidner, Fred C.....Detroit
Kimball, David C.....M
Kimberlin, Kenneth K.....M
King, Edward D.....Detroit
King, Melbourne, J.....M
Kingswood, Roy C.....Detroit
Kirchner, Augustus .....Detroit
Kirker, J. G.....Detroit
Kirschbaum, Harry M.....Detroit
Klebba, Paul .....Detroit
Klein, Wm.....Detroit
Kliger, David .....Detroit
Kline, Lewis LeRoy.....Detroit
Kline, Starr L.....Detroit
Kloeppel, C. S.....Detroit
Klosowski, Joseph .....Detroit
Klote, M. D.....Detroit
Knaggs, Charles W.....Grosse Pte.
Knaggs, Earl J.....M
Knapp, Byron .....M
Knapp, Floyd .....Detroit
Knobloch, Edmund J.....Detroit
Knoch, Hubert S.....M
Knox, Ross M.....Ecorse
Koebel, R. H. .....Detroit
Koerber, Edward J.....Detroit
Koessler, George L.....Detroit
Kohn, A. Max.....M
Kohn, M. E.....Detroit
Kokowicz, Raymond J.....M
Kolasa, W. B.....Detroit
Kopel, Joseph O.....Detroit
Korby, George J.....M
Kosanovic, Frederick, ...M
Koss, Frank R.....M
Kossayda, Adam W.....M
Koster, Koert.....Detroit
Kovach, Emery P.....Detroit
Kovan, Dennis D.....M
Koven, Abraham .....Detroit
Koslinski, Anthony E.....M
Kraft, Raymond B.....Detroit
Kraft, Ruth M.....Detroit
Krass, Edward W.....M
Krebs, Wm. T.....Detroit
Kretzschmar, C. A.....Detroit
Krieg, Earl G.....Detroit
Krieger, Harley L.....Detroit
Kreinbring, George E.....Detroit
Kritchman, M. J.....M
Kroha, Lawrence.....Detroit

Krohn, Albert H.....Detroit
Krynicki, Francis X.....Detroit
Kubanek, Joseph L.....Eloise
Kucmierz, Francis S.....M
Kuhn, Albert Arthur.....M
Kuhn, Richard F.....M
Kulaski, Chester H.....Detroit
Kullman, Harold J.....M
Kurcz, J. A.....M
Kurtz, I. J.....Detroit
Kwasiborski, S. A.....Wyandotte
Laberge, James M.....M
LaBine, Alfred C.....Detroit
LaCore, Ivan .....M
LaFerte, Alfred D.....Detroit
Laird, Robt. .....Detroit
Lakoff, Chas. .....Detroit
Lamberson, Frank A.....Detroit
La Marche, N. O.....Detroit
Lampman, H. H. .....Detroit
Landers, M. B.....Detroit
Landers, M. B., Jr.....Detroit
Lang, Leonard W.....Detroit
Lange, Anthony H.....Detroit
Lange, Wm. A.....M
Laning, George M.....Detroit
Lansky, Mandell .....M
Lapham, Fred E.....M
Larsson, Bror H.....Detroit
Lash, Michael W.....Detroit
Lasley, James W.....Detroit
Lassaline, S. J.....Detroit
Lathrop, Philip L.....Detroit
Laub, Stanley V.....M
Lauppe, Edward H.....Detroit
Lauppe, F. A.....M
Law, John H.....Detroit
Lawrence Wm. C.....Detroit
Lazar, Morton R.....M
Leach, David .....M
Leacock, Robt. C.....Detroit
Leader, L. R.....Detroit
Leaver, L. Ross.....Detroit
Lickie, Geo. C.....Detroit
Ledwidge, Patrick L.....Detroit
Lee, Harry E.....Detroit
LeGalle, Geo. M.....M
Lehman, Wm. L.....M
Leibinger, H. R.....Detroit
Leipsitz, Louis S.....M
Leiser, Rudolf .....Eloise
Leithauser, D. J.....Detroit
Leland, Sol.....M
Lemley, Clark .....Detroit
Lemmon, Charles E.....M
Lemmon, Clarence W...River Rouge
Lentine, James J.....M
Lenz, Willard.....Grosse Pointe
Lepley, Fred O.....Detroit
Lerman, S. E.....Detroit
Lescohier, Alex W....Grosse Pointe
L'Esperance, Simon P.....Detroit
Leszynski, J. S.....Detroit
Leucutia, Traian .....Detroit
Levant, Arthur B.....M
Levin, David M.....M
Levin, Michael M.....M
Levin, Samuel J.....M
Levine, Sidney S.....Detroit
Levitt, Nathan .....Detroit
Levy, Marvin B.....Detroit
Lewis, Charles T.....Detroit
Lewis, L. A.....Detroit
Lewis, J. Hugh.....M
Lewis, Wilfrid John.....M
Libbrecht, Robt. V.....Dearborn
Lichter, M. L.....M
Lichtwardt, Hartman A.....Detroit
Lieberman, B. L.....Detroit
Liddicoat, A. G.....Detroit
Lightbody, James J.....Detroit
Lignell, Rudolph.....Detroit
Lilly, Charles J.....Detroit
Lilly, Vernon S.....Detroit
Linton, James R.....Eloise
Lipinski, Stanley L.....Detroit
Lipkin, Ezra.....Detroit
Lipschutz, Louis S.....M
Livingston, George D.....M
Lockwood, Bruce C.....Detroit
Lofstrom, James E.....M
Long, Earle C.....Detroit
Long, John J.....Detroit
Loranger, C. B.....Grosse Pointe
Loranger, Guy L.....M
Lord, Herman M.....M
Lorber, Joseph H.....M
Lorentzen, Edwin H.....Detroit
Lovas, W. S.....M
Lovell, B. K.....Detroit

Lovering, Wm. J.....Detroit
Lowrie, G. B.....Detroit
Lowrie, Wm. L.....Detroit
Lowry, George L.....Detroit
Luce, Henry A.....Detroit
Lum, Thomas Kion.....M
Lutz, Earl F.....Detroit
Lynn, David H.....Detroit
Lynn, Harvey D.....Detroit
Lyons, Wm. H.....Eloise

Mabee, Frank P.....Detroit
Mabley, J. Donald.....M
MacArthur, Robt. A.....Detroit
MacCraken, Frances L.....Detroit
MacFarlane, Howard W.....Detroit
MacGregor, W. W.....Detroit
Mack, Harold C.....M
MacKenzie, Earle D.....Detroit
MacKenzie, Frank M.....Detroit
MacKenzie, John W.....Grosse Pte.
Mackersie, W. G.....Detroit
MacMillan, Francis B.....Detroit
MacMillan, James M.....M
MacMullen, Frank B.....Detroit
MacQueen, Malcolm D.....Detroit
Maczewski, John E.....Detroit
Magnell, Ralph C.....Detroit
Maguire, Clarence E.....Detroit
Mahlatjie, Nathaniel M.....Detroit
Mahoney, Hugh M.....Detroit
Maibauer, F. P.....M
Maior, Roman H.....Hamtramck
Maire, E. D.....M
Maire, Harold U.....M
Malachowski, B. T.....Detroit
Malik, Edward A.....Detroit
Malik, Nur M.....Detroit
Malina, Stephen .....Detroit
Malone, Herbert .....Detroit
Maloney, John A.....Detroit
Mancuso, Vincent S.....Detroit
Mandiberg, Jack N.....M
Manning, Morey H.....Detroit
Manting, Jacob .....Detroit
Maples, Douglas E.....M
Marcotte, Oliver .....Detroit
Marcus, Daniel B.....Detroit
Marinus, Carleton, J.....Detroit
Marion, Donald F.....M
Mark, Jerome .....M
Markoe, Rupert C. L.....Detroit
Marks, Ben .....M
Marks, Morris .....Detroit
Marsden, Thomas B.....Detroit
Marsh, A. R.....Detroit
Marshall, James R.....Detroit
Martin, Edw. G.....Detroit
Martin, Elbert A.....Detroit
Martin, I. Herbert.....Detroit
Martin, J. B., Jr.....Detroit
Martin, L. R.....Detroit
Martin, R. M.....Detroit
Martin, Wm. C. (E).....Detroit
Martinez, P. O.....Detroit
Martmer, Edgar .....M
Marwil, T. B.....M
Mason, Percy W.....Detroit
Massengile, Cleave V.....Detroit
Mateer, John G.....Detroit
Matthews, Wallace R.....Dearborn
Maun, Mark E.....Detroit
May, Earl W.....Detroit
May, Frederick T., Jr.....M
Mayer, E. V.....Detroit
Mayer, Willard D.....Detroit
Mayne, C. H.....Detroit
McAfee, F. W.....Detroit
McAlonan, Wm. T.....Detroit
McAlpine, A. D.....Detroit
McAlpine, Gordon S.....Detroit
McClellan, G. L.....Detroit
McClellan, Robt. J.....Detroit
McClendon, James J.....Detroit
McClintock, J. J.....Detroit
McClure, Robt. W.....M
McClure, Roy D.....Detroit
McClure, Wm. R.....Detroit
McColl, Charles W.....M
McColl, Clarke M.....Detroit
McColl, Kenneth M.....Detroit
McCollum, E. B.....M
McCord, Carey P.....Detroit
McCormick, Colin C.....Dearborn
McCormick, C. W.....Detroit
McCormick, F. T.....Detroit
McCullough, Lester E.....Detroit
McDonald, Angus L.....Detroit
McDonald, Grant.....Detroit
McDonald, George O.....Detroit

McDonald, Peter W.....M
McGarvah, A. W.....Detroit
McGarvah, Jos. A.....Detroit
McGee, Chas. Joseph.....Eloise
McGillicuddy, W. E.....Detroit
McGloughlin, Nicholas D.....M
Wyandotte
McGough, Joseph M.....M
McGraw, Arthur B.....M
McGuire, Ruth M.....Detroit
McIntosh, W. V.....Detroit
McKean, G. Thomas.....M
McKean, Richard M.....M
McKenna, Chas. J.....M
McKhann, C. F.....Detroit
McKinnon, John D.....Detroit
McLane, Harriet E.....Detroit
McLean, Don W.....M
McLean, Harold G.....Detroit
McMahon, Gerald H.....Detroit
McMehen, Chas. E.....Berkeley
McPherson, R. J.....Detroit
McQuiggan, Mark R.....Detroit
McQuiggan, Paul .....M
McRae, Donald H.....Detroit
Mead, John .....Detroit
Meader, F. M.....Detroit
Meek, Stuart F.....Detroit
Meinecke, H. A.....Detroit
Mellen, Hyman S.....Detroit
Melnik, Maxim P.....Detroit
Menagh, Frank R.....Detroit
Mendelssohn, R. J.....Detroit
Merkel, Charles C.....Grosse Pte.
Merrill, Wm. O.....Detroit
Merriman, K. S.....Detroit
Merritt, Earl G.....Detroit
Metzger, Harry C.....Detroit
Meyer, Ruben .....Detroit
Meyers, M. P.....M
Meyers, Solomon G.....M
Miley, H. H.....Detroit
Miller, Daniel H.....Detroit
Miller, Harry A.....M
Miller, Hazen L.....Detroit
Miller, Karl .....M
Miller, Maurice P.....Trenton
Miller, Myron H.....Detroit
Miller, T. H.....M
Miller, Wm. Ernest.....Detroit
Mills, Clinton C.....M
Mills, Georgia V.....Detroit
Mintz, Edward I.....Detroit
Miral, Solomon P.....Detroit
Mishelevich, Sophie.....Detroit
Mitchell, C. Leslie.....Detroit
Mitchell, Gertrude F.....Detroit
Mitchell, W. Bede.....M
Moehlig, Robert C.....Detroit
Moisides, V. P.....Detroit
Moll, Clarence D.....Detroit
Molner, Joseph G.....Detroit
Moloney, J. Clark.....M
Mond, Edward .....Detroit
Monfort, Willard .....Detroit
Montgomery, John C.....Detroit
Montante, Jos. R.....M
Moore, Doris Sanders.....Detroit
Moore, James A.....Detroit
Moore, Mildridge B.....Detroit
Morand, Louis J.....Detroit
Morgan, Donald Nye.....M
Moriarity, George .....Detroit
Moritz, H. C.....Detroit
Morley, Harold V.....M
Morley, James A.....Detroit
Morrison, G. W.....Detroit
Moroun, S. J.....Detroit
Morris, Harold L.....Detroit
Morrison, Marjorie G. E.....Detroit
Morse, Plinn F.....Detroit
Morton, David G.....M
Morton, John B.....Detroit
Mosee, W. Jones.....Detroit
Mosen, Max M.....Detroit
Moss, E. B.....Detroit
Moss, Nathan H.....Detroit
Mott, Carlin P.....Detroit
Muelenhagen, Walter J.....Detroit
Munson, F. T.....Detroit
Muntyan, Andrew .....Detroit
Murphy, D. J.....M
Murphy, Frank J.....M
Murphy, John M.....M
Murphy, Scipio G.....Detroit
Murphy, W. M.....Detroit
Murray, George M.....Detroit
Murray, Wm. A.....Detroit
Muske, Paul H.....M
Myers, George P.....Detroit
Myers, Gordon B.....Detroit

Nagel, Oscar .....M
Nagle, John W.....Wyandotte
Naud, Henry J.....Detroit
Nawatka, E. E.....Detroit
Naylor, A. E.....Detroit
Naylor, Arthur H.....Detroit
Neeb, Walter G.....M
Nelson, Harry M.....Detroit
Nelson, Victor E.....M
Neumann, Arthur J.....Detroit
Newbarr, Arthur A.....Detroit
Newcomer, Sheldon R.....Detroit
Newman, Max Karl.....Detroit
Nielsen, Aage E.....M
Nichamin, Samuel J.....M
Nickels, Albert W.....M
Nickerson, Dean .....M
Nigro, Norman D.....M
Nill, John B.....Detroit
Nill, Wm. F.....Detroit
Nixdorf, Wallace B.....Detroit
Noer, Rudolf J.....M
Nolting, Wilfred S.....M
Norconk, A. A.....M
Norcott, Edith S.....Detroit
Norris, Edgar H.....Detroit
Northrop, Arthur K.....Detroit
Norton, Charles S.....Detroit
Noth, Paul H.....Grosse Pte. Farms
Novy, R. L.....Detroit
Nowicki, Jos. A.....Detroit
O'Brien, E. J.....Detroit
O'Brien, G. M.....Detroit
O'Donnell, David H. (E).....Detroit
O'Donnell, Dayton H.....M
Ohmart, Galen B.....Detroit
O'Hora, James T.....Detroit
Ohrt, Harold F.....Detroit
Olenikoff, Alex .....M
Olechowski, Leo W.....M
Olmsted, Wm. R.....Detroit
Olney, H. E.....Detroit
Oman, Cyrus F.....Detroit
Oppenheim, J. M.....M
Oppenheim, Milton M.....
Highland Park
Organ, Fred W.....Detroit
Ormond, John K.....Detroit
Orecklin, L. .....Detroit
O'Rourke, Paul V.....Detroit
O'Rourke, R. M.....Detroit
Osius, Eugene .....M
Ott, Harold A.....M
Ottaway, John P.....M
Owen, Clarence I.....M
Owen, Samuel H. C.....Detroit
Palmer, Alice .....Detroit
Palmer, R. Johnston.....Detroit
Pangburn, L. E.....Detroit
Panzner, Edward J.....Detroit
Parker, Albert R.....Wayne
Parker, Benj. R.....M
Parker, Walter R. (E).....Detroit
Parkinson, Doris .....Detroit
Parr, R. W.....Detroit
Parson, John P.....Grosse Pte. Park
Pasternacki, Norbert T.....Detroit
Paterson, Walter G.....Detroit
Patton, Henry S.....M
Pawlowski, Jerome.....Detroit
Paysner, Harry A.....Detroit
Peabody, Chas. Wm.....Detroit
Peacock, L. W.....Highland Park
Pearse, Harry A.....Detroit
Peggs, George F.....M
Peirce, Howard W.....Detroit
Penberthy, G. C.....M
Pendy, John M.....M
Pensler, Meyer .....M
Pequegnot, Chas. F.....Detroit
Perdue, Grace M.....Detroit
Perkin, Frank S.....M
Perkins, Ralph A.....Grosse Pte.
Perlis, H. L.....Detroit
Perry, Alvin LaForge.....M
Peterman, Earl A.....Detroit
Petix, Samuel C.....Detroit
Pickard, O. W.....Detroit
Pierce, Frank L.....Detroit
Pierson, Max J.....Detroit
Pietraszewski, A. W.....Detroit
Pinckard, Karl G.....Dearborn
Pink, Rose M.....Detroit
Pinney, Lyman J.....Detroit
Pino, Ralph H.....Detroit
Piper, Clark C.....Detroit
Plaggemeyer, H. W.....Detroit
Pliskow, Harold .....M
Podezwa, J. W.....M
Pollock, John J.....Detroit

Poole, Marsh W.....M
Poos, Edgar E.....Detroit
Porretta, Anthony C.....Detroit
Porretta, F. S.....Detroit
Porter, H. J.....Romulus
Posner, Irving .....Detroit
Pratt, Jean P.....Detroit
Pratt, Lawrence .....M
Priborsky, Benj. H.....Detroit
Price, A. H.....Detroit
Price, A. Edwin.....M
Proctor, Bruce .....Detroit
Proud, Robt. H.....Flat Rock
Ptolemy, H. H.....Detroit
Pugliesi, Benedetto .....Detroit
Purcell, Frank H.....Detroit
Putra, A. .....M
Pyle, Wynand .....Detroit
Quigley, Wm. .....Detroit
Rahm, Lambert P.....M
Rand, Morris .....Detroit
Rao, John O.....Detroit
Raskin, John .....Detroit
Raskin, Morris,.....Highland Park
Rastello, Peter B.....Detroit
Ratigan, C. S.....Dearborn
Raynor, Harold F.....Detroit
Reed, H. Walter.....Detroit
Reed, Ivor E.....Detroit
Rees, Howard C.....Detroit
Reid, Wesley G.....M
Reiff, Morris V.....M
Reinbolt, Chas. A.....Detroit
Reinsh, Ernest R.....M
Reisman, Nathan J.....Detroit
Rekshaw, W. R.....Dearborn
Renaud, G. L. (E).....Detroit
Rennell, Leo P.....Detroit
Renz, Russell H.....Detroit
Repp, Wm. A.....Detroit
Reske, Alven.....M
Reveno, Wm. S.....Detroit
Rexford, W. K.....Detroit
Reye, H. A.....Detroit
Reyner, C. E.....Detroit
Reynolds, Lawrence .....Detroit
Reynolds, R. P.....Detroit
Rezanka, Harold J.....Grosse Pte.
Rhoades, F. P.....Detroit
Rice, Clair M., Jr.....M
Rice, Harold B.....Detroit
Rice, Meshel .....Detroit
Richards, R. Milton.....Detroit
Richardson, Allan L.....Detroit
Rick, Paul J.....Detroit
Ridge, Ralph W.....Wyandotte
Ridley, Edward R.....Detroit
Rieckhoff, Geo. G.....Detroit
Rieger, John B.....Detroit
Rieger, Mary H.....Detroit
Riseborough, E. C.....Detroit
Rizzo, Frank .....Detroit
Robb, Edward L.....Detroit
Robb, Herbert F.....Belleville
Robb, J. M.....Grosse Pte.
Robbins, Edward R.....Detroit
Roberts, Arthur J.....Ecorse
Robertson, A. E.....Detroit
Robertson, Stanley B.....Detroit
Robertson, Tom H.....Detroit
Robillard, Henry .....Detroit
Robins, Samuel C.....Detroit
Robinson, Edwin L.....Detroit
Robinson, Fred L.....Dearborn
Robinson, George W.....Detroit
Robinson, Harold A.....M
Robinson, R. G.....Detroit
Rogers, A. Z.....Grosse Pte. Wds.
Rogers, James D.....Wyandotte
Rogin, James R.....Detroit
Rogoff, A. S.....M
Rohde, Paul C.....Detroit
Rom, Jack .....M
Roman, Stanley J.....M
Roney, Eugene H.....M
Root, Charles T.....M
Rosbolt, Oscar P.....Detroit
Rose, Bernard .....Detroit
Rosen, Robt. .....Detroit
Rosenberger, Homer .....M
Rosenman, J. D.....Detroit
Rosenthal, Louis H.....M
Rosenwach, Felix F.....M
Rosenzweig, Saul .....Detroit
Ross, Arno .....M
Ross, D. G.....Grosse Pte.
Ross, Ben C.....M
Ross, Hyman .....M
Ross, Samuel H.....M
Roth, Edward T.....Detroit
Roth, Theodore I.....M

Rothstein, Hyman .....M
Rotarius, E. M.....Detroit
Rothbart, H. B.....Detroit
Rothman, Emil D.....Detroit
Rottenberg, Leon .....M
Rowda, Michael S.....Detroit
Rowell, Robt. C.....Eloise
Rowell, Wilfred J.....M
Rubright, LeRoy W.....M
Rucker, Julian J.....Detroit
Rueger, Milton J.....M
Rueger, Ralph C.....Detroit
Runge, Edward F.....Detroit
Rupprecht, Emil F.....M
Ruskin, Samuel H.....Detroit
Russell, John C.....Detroit
Rydzewski, Jos. B.....Detroit
Ryerson, Frank L.....Detroit
Sachs, Herman K.....M
Sack, A.....M
Sadowski, Roman .....Detroit
Sage, Edward O.....Detroit
Sage, Thomas .....Detroit
Sager, E. L.....Detroit
St. Amour, Hector.....Detroit
St. Louis, R. J.....River Rouge
Sakorraphos, Stelios .....Detroit
Salchow, Paul T.....Detroit
Salowich, John .....Detroit
Saltzstein, Harry C.....Detroit
Sander, I. W.....Detroit
Sanders, Alex W.....Detroit
Sanderson, A. R..Grosse Pte. Park
Sanderson, James H. (E)....Detroit
Sanderson, Joseph L.....Detroit
Sanderson, Suzanne .....Detroit
Sandler, Nathaniel .....M
Sands, G. E.....Detroit
Sandweiss, D. J.....Detroit
Sanford, Hawley S.....M
Sargent, Wm. R.....Detroit
Sauk, John J.....M
Sauter, Simon H.....Detroit
Savignac, Eugene M.....Detroit
Sawyer, Harold F.....Detroit
Scarney, Herman D.....M
Schaefer, Robt. L.....M
Schaefer, Martin .....Detroit
Schembeck, I. S.....Detroit
Schenden, A. J.....Melvindale
Schiller, A. E.....Detroit
Schilling, Charles E.....Detroit
Schinagel, Geza .....Detroit
Schirack, Ray .....Detroit
Schlacht, Geo. F.....Romulus
Schlafer, Nathan H.....Detroit
Schlemer, John H.....Detroit
Schmidt, Harry E.....M
Schmidt, J. Robt.....M
Schmidt, Milton R.....M
Schmitt, Norman L.....Detroit
Schneck, R. J.....Detroit
Schneider, Curt P.....M
Schoenfield, Gilbert D.....Detroit
Schorr, Robt. L. (E).....Detroit
Schooten, Sarah S.....Detroit
Schreiber, W. F.....Detroit
Schroeder, Carlisle F.....M
Schulte, Carl H.....Detroit
Schultz, Ernest C.....Detroit
Schultz, Robt. F.....M
Schwartz, Ben.....Detroit
Schwartz, H. Allen.....Detroit
Schwartz, Louis A.....M
Schwartz, Marvin .....Detroit
Schwartz, Oscar D.....M
Schwartzberg, Jos. .....M
Schweigert, C. F.....M
Sciarrino, Stanley V.....Detroit
Scott, J. W.....Detroit
Scott, R. J.....M
Scott, Wm. J.....Grosse Pte. Farms
Seabury, Frank P.....Detroit
Secord, Eugene W.....Detroit
Seeley, James B.....Dearborn
Seeley, Ward F.....Detroit
Segar, Lawrence F.....Detroit
Seibert, Alvin H...Grosse Pte. Park
Seiferlein, Archie L.....M
Selby, C. D.....Detroit
★Seliady, Joseph Eugene.....
Sellers, Graham .....Detroit
Selling, Lowell .....Detroit
Selman, J. H.....Detroit
Sewell, George .....Detroit
Seymour, Wm. J.....Detroit
Shafarman, Eugene.....Detroit
Shaffer, Jos. H.....M
Shaffer, Loren W.....Detroit
Shafter, Royce R.....Detroit

★Died in Military Service.

Shapiro, Oscar U.....Detroit
Shapiro, Reuben I.....M
Sharp, Martin C.....Detroit
Sharrer Chas. H.....Detroit
Shaw, Robert G.....Detroit
Shawan, H. K.....Detroit
Shebasta, Emll .....M
Sheldon, John A.....Detroit
Shelton, C. F.....M
Sheppard, Emma W.....Detroit
Sheppard, Wm. B.....M
Sheridan, Chas. R.....Detroit
Sherman, B. B.....Detroit
Sherman, Wm. L.....Detroit
Sherrin, Edgar R.....M
Sherwood, Dewitt L.....Detroit
Shewchuk, Alexander P.....M
Shields, Wm. L.....Detroit
Shifrin, Peter G.....M
Shipton, W. Harvey.....Detroit
Shlain, Benj. .....Detroit
Shore, O. J.....Detroit
Shotwell, Carlos W.....Detroit
Shulak, Irving B.....M
Shurly, Burt R.....Detroit
Siddall, Roger S.....Detroit
Sieber, Edward H.....Dearborn
Siefert, John L.....M
Siefert, Wm. A.....Detroit
Siegel, Henry .....M
Silver, Israel W.....Detroit
Silverman, I. Z.....Detroit
Silverman, M. M.....Detroit
Simon, Emil R.....Detroit
Simons, Edward J.....M
Simpson, C. E.....Detroit
Simpson, H. Lee.....Detroit
Singer, Floyd W.....Detroit
Sippola, Geo. W.....Detroit
Sisson, John M.....Detroit
Siwka, Isidore J.....Detroit
Skinner, Edward F.....Detroit
Skinner, W. Clare.....Detroit
Skolnick, Max H.....M
Skrzycki, Stephen S.....Detroit
Skully, E. J.....Detroit
Skully, G. A.....M
Sladen, Frank J.....Detroit
Slate, Raymond N.....Detroit
Slaughter, Fred M.....Detroit
Slaugenhaupt, J. G.....Detroit
Slazinski, Leo W.....Detroit
Slevin, John G.....M
Sliwin, Edward P.....M
Small, Henry .....M
Smeck, Arthur R.....Detroit
Smeltzer, Merrill.....M
Smith, F. Janney .....Detroit
Smith, Fred R.....M
Smith, C. Gerritt.....Detroit
Smith, Henry L.....Detroit
Smith, J. Allen.....Detroit
Smith, James A.....Detroit
Smith, Vine LaRue.....Detroit
Smyth, Charley J.....Eloise
Snedeker, Bernard C.....M
Snow, L. W.....Northville
Snyder, Arthur M.....Detroit
Sobin, D. J.....Detroit
Socall, Charles J.....M
Somers, Donald C.....M
Sonde, Lewis P.....Detroit
Sorock, Milton L.....M
Spademan, Loren C.....Detroit
Spalding, Edward D.....M
Sparling, Harold I.....M
Sparling, Irene L.....Northville
Speck, Carlos C.....Allen Park
Spector, Maurice J.....M
Spencer, Frank .....Detroit
Spero, Gerald.....Detroit
Sperry, Frederick L.....Detroit
Spiro, Adolph .....M
Springborn, B. R.....Detroit
Sprunk, Carl .....M
Sprunk, John P.....Detroit
Spurrier, Ethelbert .....M
Squires, W. H.....Eloise
Stafford, Claude M.....Detroit
Stafford, Frank W. J.....Detroit
Stageman, John C.....M
Stahly, Edward .....Northville
Stalker, Hugh .....Grosse Pointe
Stamell, Meyer .....M
Stamos, Harry .....Detroit
Stanton, James M.....Detroit
Stapleton, Wm. J., Jr.....Detroit
Starrs, Thomas C.....Detroit
Stefani, E. L.....Detroit
Stefani, Raymond T.....M
Steffes, Everette M.....M
Stein, Albert H.....M
Stein, Emory .....Detroit
Stein, Saul C.....M
Steinbach, Henry B.....Detroit
Steinberger, Eugene .....Detroit
Steiner, Gabriel .....Detroit
Steiner, Louis J.....Detroit
Steiner, Max .....M
Steinhardt, Milton J.....M
Stellhorn, Chester E.....Detroit
Stellhorn, M. C.....Detroit
Sterling, Lawrence .....Detroit
Sterling, Robt. R.....Detroit
Stern, Harry L.....Detroit
Stern, Leonard H.....Detroit
Stern, Louis D.....Detroit
Stevens, Rollin H. (E).....Detroit
Stewart, Thomas O.....Detroit
Stiefel, Daniel M.....Detroit
Stirling, Alex M.....Detroit
Stith, Dwight E.....Detroit
Stobbe, Godfrey D.....M
Stocker, Harry.....Detroit
Stockwell, B. W.....M
Stofer, Bert E.....Detroit
Stokfisz, T. .....M
Stolz, Harold F.....Detroit
Stout, Lindley H.....Detroit
Straith, Claire L.....Detroit
Stricker, Henry D.....Detroit
Strickroot, Fred L.....M
Strohschein, Don F.....Detroit
Stubbs, C. T.....Detroit
Stubbs, Harold W.....Detroit
Stuecheli, Milton B.....Detroit
Sugar, David I.....Detroit
Sugarman, Marcus H.....M
Sullivan, Hugh A.....Detroit
Summers, Wm. S.....Detroit
Surbis, John P.....Detroit
Sutherland, J. M.....Detroit
Swaney, Colletta M.....Detroit
Swanson, C. N.....Detroit
Swanson, Robt. G.....M
Swartz, J. N.....Detroit
Swift, Karl L.....Detroit
Switzer, Bertrand C.....Detroit
Szappanyos, Bela T.....Detroit
Szedja, J. C.....M
Szilagyi, Emerick D.....M
Szlachetka, V. E.....M
Szmigiel, A. J.....Detroit
Tamblyn, E. J.....Detroit
Tann, H. E.....Detroit
Tapert, Julius C.....Detroit
Tasker, Helen .....Detroit
Tassie, Ralph N.....Detroit
Tatelis, Gabriel .....Detroit
Taylor, Aaron .....M
Taylor, Ivan B.....M
Taylor, Nelson M.....M
Tear, Malcolm L.....M
Teitelbaum, Myer .....M
Tenaglia, Thomas A.....M
Tenerowicz, Rudolph G.....
Washington, D. C.
Test, Frederick C. II.....Detroit
Texter, Elmer C.....Detroit
Thompson, Alderman .....Detroit
Thompson, David L.....Detroit
Thompson, H. E.....Detroit
Thompson, H. O.....M
Thompson, James B.....M
Thompson, W. A.....Detroit
Thomson, Alexander .....Detroit
Thosteson, Geo. C.....Detroit
Thurston, Roger G.....M
Tichenor, E. D.....Detroit
Toepel, Otto T. (E).....Detroit
Tomsu, Charles L.....Detroit
Top, F. H.....Detroit
Torrey, H. N.....Detroit
Townsend, Frank M.....Detroit
Townsend, Kyle E.....Detroit
Trask, Harry D.....Detroit
Tragenza, W. Kenneth.....Detroit
Troester, Geo. A.....M
Trombley, Bryan .....Detroit
Trombley, Joseph J., Jr.....M
Troxell, Emmett C.....Detroit
Truog, Clarence P.....Battle Creek
Truszkowski, E. G.....M
Trythall, S. W.....Detroit
Tufford, Norman G.....Detroit
Tulloch, John .....M
Tupper, Roy D.....Detroit
Turbett, Claude W.....Detroit
Turcotte, Vincent J.....Detroit
Turkel, Henry .....Detroit
Tuttle, Wm. .....M
Tyson, Wm. E. E.....Detroit

Ujda, Chester J.....Wyandotte
Ulbrich, Henry L.....Detroit
Ulch, Harold W.....Detroit
Ulrich, Willis H.....M
Umphrey, Clarence E.....Detroit
Usher, Wm. Kay.....Detroit
Vale, C. Fremont.....Detroit
Van Auken, Edw. A.....M
Van Baalen, M. R.....Detroit
VandeVelde, Honore .....Detroit
Van Gundy, Clyde R.....Detroit
Van Heldorf, Harry .....Detroit
Van Nest, A. E.....Detroit
Van Rhee, George.....Detroit
Van Riper, Steven L.....Detroit
Vardon, Colin C.....Detroit
Vardon, Edward M.....Detroit
Vasu, V. O.....Detroit
Vergosen, Harry E.....M
Vincent, J. LeRoi.....M
Voegelin, Adolph E.....Detroit
Voelkner, Geo. H.....Detroit
Vogel, Hymen A.....Detroit
Vokes, Milton D.....Detroit
Von Der Heide, E. C.....Detroit
Vossler, A. E.....Detroit
Vreeland, C. Emerson.....Detroit

Waddington, Jos. E. G. (E)..Detroit
Wadsworth, Geo. H.....M
Waggoner, C. Stanley.....M
Waggoner, Lyle G.....Detroit
Wainger, M. J.....Detroit
Wainstock, Michael .....Detroit
Waldbott, Geo. L.....Detroit
Walker, Enos G.....M
Walker, J. Paul.....Detroit
Walker, Leo Whitney.....Detroit
Walker, Roger V.....Detroit
Walker, Sheldon A.....Detroit
Wallace, S. Willard.....Detroit
Walls, Arch .....Detroit
Walser, Howard C.....Detroit
Walsh, Chas. R.....Detroit
Walsh, Francis P.....Detroit
Walters, Albert G.....Detroit
Waltz, Frank D. B.....Detroit
Waltz, Paul J.....Detroit
Wander, Wm. G.....Detroit
Ward, W. K.....Detroit
Warden, Horace F.....Detroit
Warner, H. W.....M
Warner, P. L.....Detroit
Warren, L. P.....M
Warren, Wadsworth .....M
Wasserman, Lewis C.....Detroit
Waszak, Chas. J.....Detroit
Watkins, John P.....Detroit

Watson, Douglas J.....M
Watson, Harwood G.....Dearborn
Watson, J. Edwin.....Detroit
Watson, Robt. W.....Highland Park
Watters, F. L.....M
Watts, Frederick B.....M
Watts, John J.....Detroit
Wax, John H.....M
Wayne, M. A.....Detroit
Weaver, Clarence E.....Detroit
Weaver, Delmar F.....Detroit
Webster, John E.....M
Weed, Milton R.....M
Wehenkel, Albert M.....Detroit
Weiner, M. B.....Detroit
Weingarden, David H.....Detroit
Weinstein, Jacob .....Detroit
Weisberg, A. Allen.....M
Weisberg, Harry .....Detroit
Weisberg, Jacob .....M
Weisenthal, Irvin.....Detroit
Weiser, Frank A.....Detroit
Weiss, J. G.....M
Welch, John H.....Detroit
Weller, Charles N.....Detroit
Wellman, W. W.....Ypsilanti
Wells, Martha .....Detroit
Weltman, Carl .....Detroit
Wendel, Jacob S.....Detroit
Wenzel, Jacob F.....Detroit
Wershow, Max .....Detroit
West, Howard G.....Detroit
Weston, Earl E.....Detroit
Weston, Horace L.....M
Westover, Charles .....Plymouth
Weyher, Russell F.....Detroit
Whalen, Neil J.....Detroit
Wharton, Thomas V.....Wyandotte
Whinnery, R. A.....Detroit
White, Milo R.....Detroit
White, Milton W.....Detroit
White, Prosper D., Jr.....M
White, Theodore M.....Detroit
Whitehead, L. S.....M
Whitehead, Walter K.....Detroit
Whiteley, Robt. K.....M
Whitney, Elmer L.....Detroit
Whitney, Rex E.....M
Whittaker, Alfred H.....Detroit
Wiant, R. E.....Detroit
Wickham, A. B.....Detroit
Wiechowski, Henry E.....M
Wiener, I. .....M
Wight, Fred B.....Detroit
Wilcox, L. F.....M
Wilkinson, A. P.....Detroit
Williams, C. J.....Detroit
Williamson, Edwin M.....M

Williamson, John C.....Dearborn
Wills, J. N.....Detroit
Willson, W. N.....M
Wilson, Stuart .....M
Wilson, Gerald A.....Detroit
Wilson, John D.....Detroit
Wilson, M. C.....M
Wilson, Walter J.....Detroit
Wilson, Walter J., Jr.....M
Winfield, James M.....M
Winsor, Carleton .....M
Wiren, Lennart W.....Detroit
Wishropp, E. A.....M
Wisner, Harold E.....Detroit
Wissman, H. C.....Detroit
Wittenberg, Arthur A.....Detroit
Wittenberg, Samson S.....Detroit
Wittenberg, Sydney S.....Detroit
Witter, Frank .....Detroit
Witter, Joseph A.....M
Witwer, Eldwin R...Grosse Pte. Park
Wolfe, Max O.....Detroit
Wollenberg, R. A. C.....Detroit
Wood, W. C.....Detroit
Woodry, Norman L.....Detroit
Woods, H. B.....Detroit
Woods, W. Edward.....Detroit
Woodworth, Wm. P.....Detroit
Worznaik, Joseph J.....Detroit
Wreggit, W. R.....M
Wruble, Joseph .....Detroit
Wunsch, Richard E.....M
Wygant, Thelma.....Detroit
★ Wytowich, Walter.....Detroit

Yesayian, H. C.....Detroit
Yonkman, Frederick F.....Detroit
York, Frederick P.....M
Yott, Wm. J.....M
Young, Donald A.....M
Young, Donald C.....M
Young, James P.....Detroit
Young, Lloyd B.....M
Young, Viola M.....Detroit

Zaik, Edward J.....Detroit
Zbudowski, A. S.....M
Zbudowski, Myron R.....M
Zemens, Joseph L.....Detroit
Zielinski, Chas. J.....Detroit
Zimmerman, I. J.....M
Zimmerman, R. L.....Detroit
Zinn, Geo. H.....Detroit
Zinterhofer, John.....Detroit
Zinterhofer, Louis.....Detroit
Zlatkin, Louis.....Detroit
Zolliker, Carl R.....Detroit
Zuelzer, Wolfgang.....Detroit
Zukowski, Sigmund A.....M

Wexford-Kalkaska-Missaukee Counties

Albi, R. W.....M
Atkinson, C. F.....Lake City
Daugherty, R.....M
Gruber, John F.....Cadillac
Hoagland, F. L.....M
Holm, Augustus.....Leroy
Holm, Benton.....Darling, Pa.

Hoverter, J. W.....Evart
Inman, J. C.....M
Lommen, Ralph.....Manton
McCall, James H.....Lake City
McManus, Edwin.....Mesick
Merritt, C. E.....Manton
Mills, Robt. E.....Boon
Moore, G. P.....M

Moore, Sair C.....Cadillac
Murphy, Michael R.....Cadillac
Purdy, Calvin S.....Buckley
Seltzer, S. N.....Marion
Showalter, L. E.....M
Smith, Wallace J.....Cadillac
Tornberg, Gordon C.....Cadillac

YOU AND YOUR BUSINESS

AMA OPENS WASHINGTON, D. C., OFFICE

The Washington, D. C. office of the American Medical Association was opened on April 3 at 1835 I. Street, N. W. Room 900 in Columbia Medical Building has been leased as Washington headquarters. The telephone number is EXecutive 3257.

The establishment of the Washington information office will receive the approbation of every Doctor of Medicine who has appreciated the need of this action for some time. The office will be under the direction of the Council on Medical Service and Public Relations and its Secretary, and in direct charge, for the time being, of Joseph S. Lawrence, M.D., of Albany, New York who has represented the New York State Medical Society in Albany for over twenty years.

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EMIC PROGRAM

A subcommittee of the Committee on Appropriations, U. S. House of Representatives, conducted a hearing in April to consider the request of the U. S. Children's Bureau for an additional appropriation of $42,800,000 to carry on the Emergency Maternal and Infant Care Program (which to date has cost over $24,000,000). The American Medical Association was represented at the hearing in Washington and presented the views of the AMA House of Delegates with respect to this program of governmental medicine.

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DUES AND ASSESSMENTS, 1944

The Michigan State Medical Society annual dues are $12. A special assessment for 1944, for public educational purposes, was levied by the MSMS House of Delegates last September. Membership cards are issued only upon payment of $22 to the State Society, representing the regular dues and the special assessment of 1944.

The assessment is prorated for NEW MEMBERS only, according to the quarter of the year in which the new members are certified to the State Society, similar to the arrangement provided for dues in Chapter 1, Section 3 of the MSMS By-Laws.

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DISPENSING OF VITAMINS, CAMPHORATED OIL AND BORIC ACID

The dispensing by a factory or store of individual vitamin pills is prevented by the Michigan Pharmacy Law, but there is nothing in the law to prevent the plant or shop from distributing them in original unbroken packages, provided they are distributed as a food supplement.

The 1941 Michigan Legislature passed the Trade Diversion Act which prevents manufacturers from selling to their employes any item manufactured by another manufacturer.

A Doctor of Medicine in the plant, shop, or store, has the legal right to dispense whatever vitamins or any other medicines he may desire to dispense.

Camphorated oil and boric acid are household remedies and therefore exempt from the provisions of the Pharmacy Act restricting the sale of drugs, official in the U. S. Pharmacopoeia, to license drug stores, according to a recent Circuit Court decision in Muskegon (State of Michigan vs. Anderson). This is the first court test in Michigan to consider that particular phase of exemption set forth in the Michigan Pharmacy Law.

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"HEALTH INSURANCE FOR CANADA"

An excellently prepared brochure on "Health Insurance for Canada" has been published by the Research Bureau of the Canadian Pharmaceutical Manufacturers Association, P. O. Box 22, Terminal "A", Toronto, Canada. Complimentary copies are available upon request.

The following paragraph, titled "Too Much Sickness Insurance, Not Enough Health Insurance" is typical of the thought given to this brochure.

"The terms 'sickness insurance' and 'health insurance' connote two quite different things. Sickness insurance concerns itself with facilitating the recovery of people from sickness, once it has overtaken them. Health Insurance concerns itself with minimizing the hazards that are likely to make them sick. On the theory that the more effective health insurance is made, the less will be the costs for sickness insurance, it would seem only logical that Canada should be planning to spend more and more on preventive measures that will be permanent in their beneficial effect, so that she may look forward to having to spend less and less on medical services that merely put a temporary stop to troubles that need not have happened."

* * *

FEES AND BILLING UNDER AFFLICTED CHILD ACT

Under the provisions of the Crippled and Afflicted Children's Acts, physicians are entitled to a fee for the examination of a crippled or afflicted child to determine the medical need for hospital care. The fee for this examination is $1.50.

The physician is urged to furnish complete information on the physician-surgeon certificate (Form MCCC 121) as to the nature of the illness and the treatment recommended so that the Commission may have sufficient information available to determine the classification of the child under the State Acts, the extent of services required, and for proper completion of Commission records.

Billing forms for this purpose (Voucher A-75-R) may be obtained from the hospital or the Judge of Probate and should be requested at the same time as

the physician-surgeon certificate is obtained. Physicians should bill on the prescribed form within 60 days following the examination and should obtain the signature of the Judge of Probate indicating his approval of the service rendered. This billing should be forwarded to the Michigan Crippled Children's Commission, 458 Hollister Building, Lansing, Michigan, by the Judge of Probate or by the physician himself.

The examination fee will not be allowed when the physician who makes the examination determining the medical need is the physician who attends the child in the hospital.

MSMS RADIO HOUR OVER WJR

Beginning April 27, the MSMS Radio Committee began a weekly radio period over Station WJR, Detroit. Arrangements were completed through the coöperation of the officials of WJR and the Extension Division of the University of Michigan. Talks will be given every Thursday evening, 11:15 p.m.

The program through May includes "Modern Treatment of Arthritis" by Richard H. Freyberg, M.D., Ann Arbor; "Accidents in Childhood" by Earnest H. Watson, M.D., Ann Arbor; "Postwar Problems Relative to Tropical Diseases," Robert A. Hettig, M.D., Ann Arbor; "Sick Headaches: Their Significance and Treatment," Russell N. DeJong, M.D., Chairman MSMS Radio Committee; "Swelling of the Ankles," Richard H. Lyons, M.D., Ann Arbor.

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CLINIC DAY, FORT CUSTER, JUNE 21

The War-Time Graduate Medical Meetings Committee announces the second Clinic Day in its Michigan program to be held at the Station Hospital, Fort Custer, on Wednesday, June 21.

The tentative program is as follows:

1. Convalescent Reconditioning Program at the Station Hospital—Orientation and demonstration of the class in progress. 1:00 to 1:50 p.m.
2. Malaria Control — Environmental and Individual Demonstration by "County Fair" Method. Put on by line officers and troops of the Military Police Replacement Training Center, followed by an inspection of the Field Sanitation Device Area. 2:00 to 2:55 p.m.
3. Foot and Back Clinic. 3:05 to 3:55 p.m.
4. Demonstration of Military Medical Boards in session:—(a) Disposition Board; (b) CDD Board (Certificate of Disability for Discharge—medical discharge). 4:00 to 5:00 p.m.
5. Picnic! Nurses and Officers Mess.

J. M. Robb, M.D., Detroit
Michigan Chairman



MICHIGAN'S DEPARTMENT OF HEALTH

H. ALLEN MOYER, M.D., Commissioner, Lansing, Michigan

MENINGITIS AMONG NEWBORN TRACED TO SALMONELLA PANAMA

The recent high incidence of meningitis of the newborn in Battle Creek and vicinity has been found to be due to Salmonella panama, a bacillus belonging to the enteric group and closely related to the typhoid bacillus.

Salmonella panama which, in older children and adults, generally causes a moderate gastroenteritis, may invade the blood stream in the very young and result in a meningitis with a high fatality rate.

An outbreak of this infection in hospital nurseries can be brought under control by the adoption of a technique similar to that used for the control of typhoid and other intestinal infections.

A number of carriers of the Salmonella panama have been discovered among adults which is very significant. At present all known carriers are being given the same supervision by local full-time health departments as are typhoid carriers.

More positive cases are now (May 2, 1944) on record in the Battle Creek area than are listed in previous history.

SEVEN DISEASES ABOVE SEVEN YEAR MEDIAN

During March the incidence of the following communicable diseases in Michigan was above the seven year median according to the Bureau of Epidemiology of the Michigan Department of Health:

	March 1944	Median 7 years
Meningococcic meningitis	138	6
Measles	6526	1490
Tuberculosis	607	498
Diphtheria	27	25
Undulant Fever	9	8
Syphilis	1488	936
Gonorrhea	1078	576

NEW DIARRHEA AND ENTERITIS CONTROL SERVICE OFFERED

Announcement is made by the Michigan Department of Health and the W. K. Kellogg Foundation that a diarrhea and enteritis study group which has been in training for a year is now ready to give assistance to hospitals experiencing active outbreaks of nursery diarrhea.

The study group is in charge of a licensed physician and is made up of two sections, one working in the field and the other in the laboratory.

The field section consists of a physician, two graduate nurses and a medical secretary. This staff will collect clinical, epidemiologic, sanitary and laboratory data and give clinical and control assistance. Additional medical, nursing and engineering specialists will be recruited locally when needed and paid from study funds.

The laboratory section is composed of two bacteriologists, one virologist, five laboratory assistants and one secretary. This group has been especially trained and equipped to analyze all types of laboratory specimens sent in from the hospitals.

Field operations will be limited to Michigan, northern Ohio and northern Indiana. Notification that the diarrhea and enteritis study group is now ready for duty has been sent to state and local medical societies in this area and to hospital administrators, secretaries of hospital associations and state and local health officers. Any hospital experiencing an active outbreak of nursery diarrhea may request the services of the study group. The cost of field operations will be borne by the W. K. Kellogg Foundation and the Department. Requests should be made by telephone to Dr. C. C. Young, Director of Laboratories, Michigan Department of Health.

STATEWIDE PLASMA PROGRAM IN OPERATION

Enlarging of facilities will be undertaken at once for the processing of blood plasma in the state health department's Lansing laboratories. Planned construction will provide an additional 3,900 square feet of floor space, permitting the quadrupling of present production and the supplying of plasma to all Michigan communities.

A $250,000 appropriation was voted for the enlarging of the state's plasma program during the recent special session of the legislature.

Physicians are supplied with the plasma, free of charge, for the treatment of civilian patients. Its use is urged in the treatment of shock resulting from accident, surgical operations or burns, and from hemorrhages complicating such diseases as typhoid, dysentery and diarrhea of the newborn.

MICHIGAN DEATHS DUE TO CANCER

Bringing Michigan's cancer death rate to an all-time high, 6,807 deaths from cancer were reported in 1943. Cancer accounted for twelve of each 100 deaths, ranking second only to heart disease as a cause of death.

The steady rise of the cancer death rate may be explained in part by the improvement in diagnostic methods which, each year, places increasing numbers of deaths in the cancer column. Some authorities, however, believe there is an actual increase each year in the number of persons in whom cancer develops. Also, cancer claims more victims in the higher age brackets and the average life span has been steadily lengthened.

FARM WORKERS NEED TETANUS TOXOID

Immunizing of farm workers against lockjaw is advised by the state health department, whose records show that in Michigan seven out of every ten deaths from lockjaw occur in farm families.

Production of the tetanus toxoid was started in health department laboratories when Pearl Harbor cast the shadow of bombing threats over the nation's industrial centers. Distribution of the tetanus toxoid was started a year ago this month. So far the largest quantities of the toxoid have gone to the Detroit area.



In patients with marked apathy and associated low muscle tone and low resistance, dramatic response may often be effected by adrenal cortex therapy when these symptoms are due to adrenal cortical insufficiency.

Adrenal Cortex Extract (Upjohn) used as replacement therapy in these cases often restores alertness and a healthy outlook. It relieves asthenia, strikingly increases resistance to infection, improves capacity for work, and strengthens muscle tone. Available for subcutaneous, intramuscular, and intravenous therapy.

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Woman's Auxiliary

COUNTY PRESIDENTS

County presidents are requested to send Mrs. Wm. Hubbard, 1205 Marine Street, Flint, the names and present address of your members who are with their husbands in service or at any address other than their regular one.

The Woman's Auxiliary to the AMA will convene for their national convention June 12-15 at the Knickerbocker Hotel, Chicago. County presidents are invited to notify Mrs. Otto Hult, 1204 Lake Shore Drive, Gladstone, concerning members who hope to attend.

INGHAM COUNTY

The auxiliary to the Ingham County Medical Society had a Bohemian dinner in February at the home of Mrs. O. M. Randall. Dr. Clara Shepherd spoke on "China."

Mrs. L. M. Snyder opened her home on March 20th for a guest day of the Auxiliary. The sum of one hundred dollars was voted for the Red Cross. Dr. H. C. Batson, director of the biological division of the State Department of Health Laboratories, spoke on "Trends in Modern Therapy."

ST. CLAIR COUNTY

The March meeting of the Auxiliary was held at The Chateau in Port Huron. Dr. J. A. Dunn, technical director of the Diamond Crystal Salt Company in St. Clair, spoke on "The Latest Developments in Food."

THE FUNCTION OF THE WOMAN'S AUXILIARY

At the annual session of the State Auxiliary in Detroit, 1943, President H. H. Cummings M.D., paid generous tribute to the wives of the doctors and made most of us feel that we have an important job to do and one that apparently we are doing fairly well. He said, "Woman is the generator—the dynamo—that makes a successful physician. Women create in the home a quiet place where the doctor can come for peace. He goes out with new vigor to meet the cares and problems of the present day."

F. E. Reeder, M.D., Chairman of the Advisory Council, also spoke with sincerity and feeling: "Physicians today have a double duty—they have not only to keep up the traditions of the practice of medicine, but are now on the defensive attempting to prevent the destruction of the practice of medicine. There has never been a crisis in which the medical profession has not functioned in the defense and relief of our country, but it is now on the verge of persecution. The strength of any nation is the health of its people and regimentation will not furnish the safeguard to health that the present system furnishes."

Mrs. Eben Carey, President of the National Auxiliary, brought home a point that perhaps has been taken more or less for granted: "It is only because our husbands are physicians that we have the privilege of membership in the Auxiliary." Apparently we do not value this membership sufficiently or we would safeguard it by being more interested in the future of the medical profession. We have become interested in many activities because of the present grave situation of the world and the need for volunteer workers in every field. But our husbands should be our chief concern and duty. We must not lose ourselves so completely in other interests that when this war is over our husbands will find themselves without a profession.

Golf Tournament at A.M.A. Monday, June 12, The American Medical Golfing Association will hold its 29th Annual Tournament at Flossmour Country Club, Chicago. All AMA Fellows are invited to attend. Applications for Fellowship may be obtained by writing Bill Burns, 916 N. Capitol, Lansing 6, Michigan.

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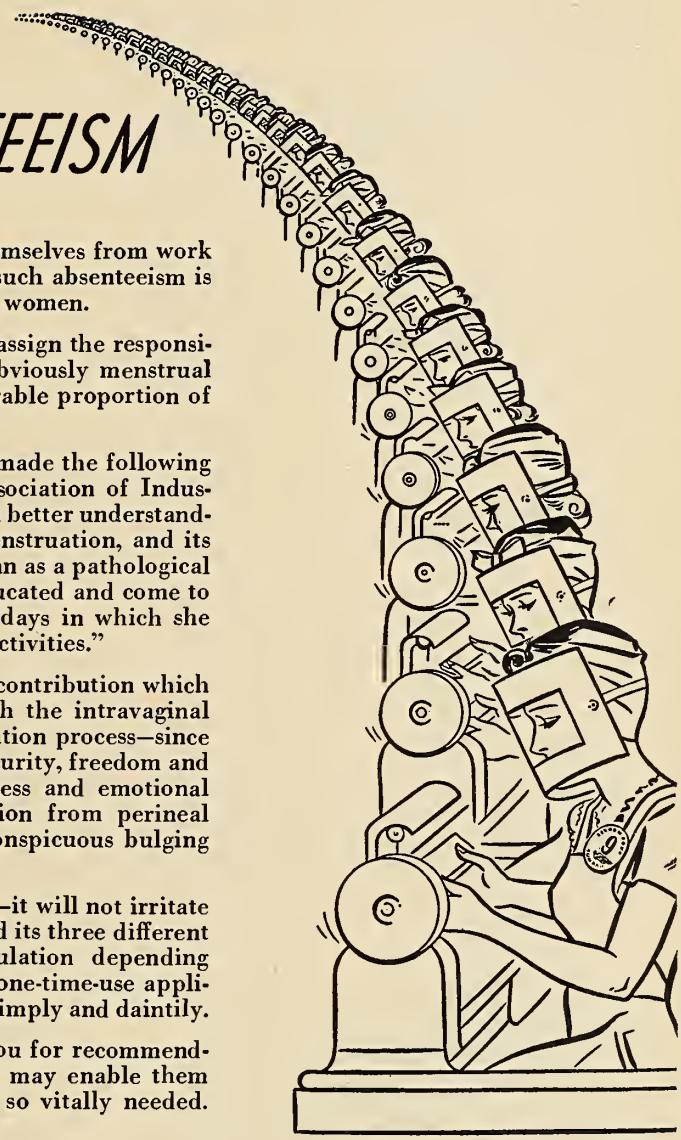
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Statistics show that women absent themselves from work much more often than men; indeed, such absenteeism is said to be 50 per cent[1] higher among women.

Though available data do not clearly assign the responsibility for this marked differential, obviously menstrual inconveniences account for a considerable proportion of the days lost.

On this point Pommerenke[2] recently made the following observation before the American Association of Industrial Physicians and Surgeons: "With a better understanding of the purpose and nature of menstruation, and its recognition as physiological rather than as a pathological process, many a woman may be re-educated and come to regard the so-called difficult days as days in which she need not seriously curtail her usual activities."

Many physicians have discovered the contribution which *improved menstrual hygiene* (as with the intravaginal tampon Tampax) affords this reeducation process—since it provides such a welcome sense of security, freedom and poise by relieving the physical distress and emotional uncertainty caused by vulval irritation from perineal pads, or from olfactory offense, or conspicuous bulging under slacks or coveralls.

Tampax can be used easily and safely—it will not irritate delicate tissues nor block the flow. And its three different absorbencies permit individual regulation depending upon daily needs. Compressed into a one-time-use applicator, it may be inserted and removed simply and daintily.

Your patients should be grateful to you for recommending Tampax—and (in many cases) it may enable them to stay "on the job" where they are so vitally needed.

(1) Mod. Med., 11:130, 1943; (2) Ind. Med., 12:512, 1943

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IN MEMORIAM

DIED IN MILITARY SERVICE

Joseph Eugene Seliady of Detroit was born March 18, 1902 in Hungary, and was graduated from the Detroit College of Medicine and Surgery in 1932. He interned at Eloise Hospital and then became associated with the Eastlawn Sanitarium in Northville, in which community he also engaged in the private practice of medicine. He entered military service in the Army of the United States in May 1942 and was stationed at Camp Hulen, Palacios, Texas. His death occurred at Fort Sam Houston, Texas, on November 20, 1943, as a result of complications following a gall-bladder surgery.

Charles W. Ash of Bay City was born in the year 1877 and was graduated from the Detroit College of Medicine in 1903. Doctor Ash practiced medicine and surgery in Bay City for many years. He was president of Bay County Medical Society in 1930 and in 1941 was elected to Retired Membership in the Michigan State Medical Society. Doctor Ash died March 5, 1944.

Gordon H. Bahman of Flint was born March 3, 1887 in Marietta, Ohio and was graduated from the University of Michigan Medical School in 1913. After graduation, he opened his practice of medicine in Flint. Doctor Bahman was active in civilian defense, having been director of emergency medical services for the Flint Council of Defense. He organized special emergency defense staffs for Hurley, St. Joseph and Women's Hospitals. Commissioned a first lieutenant in World War 1, Doctor Bahman went overseas working in eye-ear-nose-throat. When stationed at a hospital center at Gievers near the City of Tours, France, he was promoted to captain. He was honorably discharged in 1919. He died on December 23, 1943.

Harry S. Berman of Detroit was born in the year 1890 and was graduated from the College of Physicians and Surgeons of Baltimore. Doctor Berman practiced in Detroit for many years, limiting his work to pediatrics. He served in World War I, as a captain and worked on the Hoover Relief Commission in Czechoslovakia. Failing in efforts to reenlist in World War II, he accepted the Medical Chairmanship of the Selective Service Board at Harper Hospital. Dr. Berman had many veteran affiliations. His large practice did not prevent him from participating in the various national and local medical meetings, conferences and postgraduate studies all of which was reflected in his mastery of diagnosis and treatment of pediatric problems. He died February 16, 1944.

Constance M. Colignon of Muskegon was born in the year 1890 and was graduated from the University of Illinois in 1914. Two years later he began his practice of medicine in Muskegon. He organized and directed the medical service of Campbell, Wyant and Cannon Foundry Company, the largest

grey iron foundry in the world, making it one of the outstanding industrial medical departments in the country. Entering the medical corps of the army immediately after the declaration of war in 1917, Captain Colignon served overseas as surgeon with the 120th machine gun battalion of the 32nd division. In 1936 Doctor Colignon served the Muskegon County Medical Society as president. He died January 21, 1944.

Elmer A. Drolshagen of Detroit was born in 1894 and was graduated from Wayne University College of Medicine in 1917. He was a former Wayne County Medical Examiner. A native Detroiter, he served as a lieutenant in the Army Medical Corps in World War I. Doctor Drolshagen was active in many civic organizations. He died January 14, 1944.

Charles C. Landon of Battle Creek was born in 1859 and was graduated from the Hahnemann Medical College of Chicago in 1885. He practiced in Augusta for four years and then moved to Battle Creek where he was active in his profession until a year ago. Doctor Landon was elected to Emeritus Membership of the Michigan State Medical Society in 1939. In addition to his medical practice and the various medical societies of which he was a member, Doctor Landon found time to devote to many community activities. He had served as a member of the Battle Creek board of education for many years. Doctor Landon died February 7, 1944, after having been confined to his bed since 1942.

George Louis LeFevre of Muskegon was born October 22, 1865 on Grand Isle in Lake Champlain and was graduated from the Hahnemann Medical College of Chicago in 1891. He passed the State Board of Pharmacy in 1883, and at his death was Michigan's oldest registered pharmacist. For sixteen years, Doctor LeFevre served on the Michigan State Board of Registration in Medicine. Twice president, he was for years medico-legal advisor of the Muskegon County Medical Society. In 1933 he served as President of the Michigan State Medical Society. He also was a fellow of the American Medical Association and of the Surgeons' Club of Mayo Clinic. He was admitted to fellowship in the American College of Surgeons in 1915. The year after its founding. He aided in obtaining Mercy Hospital for Muskegon and served as its chief of staff from the time of its inception until 1942, when he became chief emeritus. He also served on the staff at Hackley hospital. Doctor LeFevre aided in obtaining the Muskegon County Tuberclosis Sanatorium and following its opening in 1924 he served as president of its board of trustees until his death. Besides being a leader in his profession, he was always interested in many civic affairs. In 1941 he was honored by the community and physicians of Michigan and the nation when he observed his golden anniversary as a physician. Doctor LeFevre died March 10, 1944.

James C. MacGregor of Flint was born January 19, 1872 at Taymouth, Saginaw County and was graduated from the Detroit College of Medicine in 1898. After graduation, he opened his practice of medicine in Flint. For many years he was a member of the Board of Hospital Managers of Hurley Hospital and served during the construction of the present building. Doctor MacGregor was president of the Genesee County Medical Society in 1933. He

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served on the Board of Directors of the Industrial Savings Bank and the Union Industrial Trust and Savings Bank and the National Bank of Flint. He was active in many fraternal and civic organizations. Dr. MacGregor died on February 29, 1944.

Jacob Earl Meengs of Grand Rapids was born in 1881 at Holland, and was graduated from Rush Medical School in 1904. Postgraduate work was taken by Doctor Meengs at Berlin, Munich and Vienna. From 1911 to 1913 he was resident physician at Lennox Hill Hospital in New York. For the next two years he was assistant to Doctor Max Einhorn, noted gastroenterologist of New York City, then he returned to Grand Rapids to continue his practice. Doctor Meengs specialized in gastroenterology and pathology until he was taken ill two months ago. He died February 3, 1944.

George H. Palmerlee of Detroit was born in 1872 at Romeo and was graduated from the Detroit College of Medicine in 1903. Dr. Palmerlee practiced and specialized in surgery for more than forty years in Detroit. He was a veteran of the Spanish-American War and held the rank of major in the National Guard until his retirement. Doctor Palmerlee died January 24, 1944.

Harley A. Sears of Coldwater was born in 1897 in Canada and was graduated from Queens University, Faculty of Medicine, Kingston. For many years he was assistant medical superintendent of the Kalamazoo State Hospital and a member of the staff for 21 years. Since February 1943, he had been superintendent of the Coldwater State Home and Training School. Doctor Sears died on March 9, 1944.

Clayton Myron Spencer of Scottsville was born in 1884 near Kalamazoo and was graduated from the University of Michigan Medical School in 1906. He practiced in Freesoil and after World War I, located in Scottsville. In community life he was active, serving as mayor and also as director of the Scottsville State Savings bank. Doctor Spencer died January 31, 1944.

Robert J. Walker of Saugatuck was born July 11, 1869 in Strathroy, Ontario and was graduated from the Medical Faculty of Trinity University of Toronto in 1895. Doctor Walker opened his practice in Saugatuck in 1895 where he gave 48 years of service to the community. Active in civic affairs, Doctor Walker served several years on the school board, was director of the Fruitgrowers State Bank for 35 years, 12 of which he was chairman of the board. In World War I, Doctor Walker served as a lieutenant. He died on December 11, 1943, following an automobile accident.

Is it fair always to take and never give? Is it not logical to assume that many members of organized medicine are receiving its benefit but contributing nothing in return? In the main it may be stated that those physicians who complain most of getting so little benefit from organized medicine are, after all, putting in little. Can one accept the right to criticize if he has nothing constructive to offer as a substitute?—*Jour. Missouri M.A.*

Say you saw it in the Journal of the Michigan State Medical Society

COUNTY AND PERSONAL ACTIVITIES

100 PER CENT CLUB FOR 1944

Allegan—J. E. Mahan, Secretary
Alpena-Alcona-Presque Isle—E. S. Parmenter, Secretary
Barry—H. S. Wedel, Secretary
Branch—James Bailey, Secretary
Clinton—T. Y. Ho, Secretary
Dickinson-Iron—E. B. Andersen, Secretary
Eaton—L. G. Sevener, Secretary
Grand Traverse-Leelanau-Benzie—Robert T. Lossman, Secretary
Hillsdale—John A. MacNeal, Secretary
Houghton-Baraga-Keweenaw—R. J. MuClure, Secretary
Huron—J. Bates Henderson, Secretary
Livingston—Ray M. Duffy, Secretary
Luce—Sidney Franklin, Secretary
Manistee—C. L. Grant, Secretary
Mecosta-Osceola-Lake—John A. White, Secretary
Medical Society of North Central Counties—Stanley A. Stealy, Secretary
Menominee—Wm. S. Jones, Secretary
Muskegon—Helen S. Barnard, Secretary
Newaygo—H. R. Moore, Secretary
Oceana—W. Heard, Secretary
Ontonagon—W. F. Strong, Secretary
Sanilac—E. W. Blanchard, Secretary
Tuscola—John C. Shoemaker, Secretary

As of May 10, the above county medical societies have certified 1944 dues for every member of their respective societies, to be the first 100 per cent paid-up counties for this year. A number of other societies have certified all but one or two of their 1944 members. As soon as these have paid their 1944 dues the list of 100 per cent county societies will be much larger.

American Public Health Association will hold its Second Wartime Public Health Conference in New York City, October 3-4-5, Hotel Pennsylvania.

* * *

American Hospital Association will hold its 46th Annual Convention in Cleveland, October 2-6, inclusive. The Statler Hotel will be headquarters.

* * *

E. F. Skinner, M.D., Detroit, is the author of an article "Lead Buttons for Intrapulmonary Localization," which appeared in *The Journal of Thoracic Surgery,* December, 1943.

* * *

The Upper Peninsula Medical Society will hold its Annual Meeting at Houghton, Michigan, on Thursday and Friday, July 27 and 28. Charles R. Smith, M.D., Houghton, is secretary.

Applying Scientific Principles to a Good Idea

Scientific principles applied to the early automobile brought improvements resulting in a device that changed a way of life.

There has long been a general agreement as to the particular merit of tar preparations in the treatment of eczema (1) and chronic industrial dermatoses (2). Application of scientific principles to that good idea have brought forward a modern therapeutic agent that retains the values inherent in the base tars, yet avoids the objectionable features of early whole tar preparations. It is Tarbonis Cream.

It is a pleasant vanishing type cream that is clinically nonallergic and nonirritating, without odor. It is antipruritic, and has a background of excellent clinical acceptance.

It is especially recommended in the treatment of infantile eczema, seborrheic and eczematoid dermatitis, and the many forms of industrial dermatoses.



An unusual interest, resulting in many requests for literature and samples, may cause a slight delay, but these requests will be met in the order they're received.

(1) Diseases of Infancy and Childhood, L. Emmett Holt, Jr., M.D., and Rustin McIntosh, M.D., 11th Ed., p. 905, D. Appleton-Century Co., New York, 1940.

(2) Occupational Diseases, R. T. Johnson, M.D., p. 455, W. B. Sanders Company, Philadelphia, 1941.

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"Continuous Caudal Analgesia in Obstetrics"—a motion picture in color—is available for showing before county medical societies and hospital staffs. This film was made at the U. S. Marine Hospital, Staten Island, by authorization of the Surgeon General, USPHS. For copies write Eli Lilly & Company, Indianapolis, Ind.

* * *

Max R. Burnell, M.D., Flint, is the author of an original article, "Health Maintenance Program for Women in Industry," which appeared in JAMA of March 11.

* * *

Roger V. Walker, M.D., Detroit, has been appointed a member of the Detroit Board of Health to succeed the late Frank A. Kelly, M.D. Congratulations, Dr. Walker!

* * *

James Milton Robb, M.D., Detroit, recently presented to the Wayne University College of Medicine, Detroit, a fund for the use of the Alpha Omega Alpha Scholarship and Lectureship Foundation.

* * *

"Eyes for Tomorrow" is the title of a two-reel film which stresses good general health as a prerequisite for good eyesight. The film, in sixteen and thirty-five mm., is distributed by the National Society for the Prevention of Blindness, 1790 Broadway, New York.

* * *

Wm. A. Hyland, M.D., Grand Rapids, has been appointed chairman of the Grand Rapids Arrangements Committee for the 1944 Annual Session of the Michigan State Medical Society. Dr. Hyland has served in this capacity on previous occasions and is well qualified to handle the many details of this position.

* * *

"The Organization of a Red Blood Cell Transfusion Service" and "Use of Salvaged Red Cells" are the titles of original articles by W. B. Cooksey, M.D., Detroit, written in collaboration with Major Earl S. Taylor, MC, AUS, William Thalhimer, M.D., Detroit, and Capt. William H. Horwitz, MC, AUS, which appeared in JAMA of April 1.

* * *

Clipping Coupons is always a profitable exercise, especially the coupons in the advertisements of friends who use the MSMS JOURNAL to carry their message to the Michigan medical profession. Many advertisers gauge reader interest by the number of coupons clipped and mailed to them by doctors of medicine. As a part owner of the MSMS JOURNAL, your personal interest will be served every time you clip an advertiser's coupon.

* * *

The American Medical Association will meet in Chicago the week of June 12. The House of Delegates and the scientific meetings and exhibits will be housed in the Palmer House; the technical exhibits will be in the Stevens Hotel.

The transportation and hotel facilities of Chicago are likely to be packed to the utmost under war conditions;

Say you saw it in the Journal of the Michigan State Medical Society

those planning to attend the AMA Session should make necessary reservations now. The official announcement and hotel reservation blank will appear in the JAMA (advertising pages) in the near future.

* * *

Floyd E. Armstrong, Professor of Economics and Finance and Head of the Department, Massachussetts Institute of Technology, Cambridge, Massachussetts, has addressed a number of Michigan groups on "Federal Bureaucracy" since his appearance at the MSMS Secretaries Conference of January 30 in Detroit. His schedule has been the following:

February 3, Peoples Forum, Battle Creek; February 29, Fifth Council Districts, Grand Rapids; March 7, Michigan Bottlers Association, Grand Rapids; March 9, Rotary Club, Muskegon; March 10, Woman's Auxiliary to Wayne County Medical Sosciety, Detroit; March 28, Rotary Club, Traverse City; March 28, P.T.A., Lions-Women's Clubs, Newaygo; March 30, Kiwanis Club, Saginaw; April 12, Alma College, Alma; April 18, Kiwanis Club, Hillsdale; April 21, Rotary Club, Lansing; April 24, Chamber of Commerce, Fremont; April 25, Rotary-Kiwanis-W.A., Lapeer; May 3, Public Meeting—Auxiliary to Bay County Medical Society, Bay City; May 9, Rotary-Exchange-Lions Clubs, Birmingham; May 25, Public Meeting—Auxiliary to Manistee County Medical Society, Manistee.

* * *

The Wayne County Medical Society's "Medical Information Service" is a central point of reference and assistance for people in the community needing medical care, or who otherwise are faced with health problems. This public service department is maintained by the Society in the headquarters building and is available 24 hours a day by telephone. An impartial rotating method is used in referring patients to doctors; three names are given in each instance, unless the inquirer has a family physician in which case advice is given to the effect that the family doctor is best qualified to recommend further necessary care. The records are arranged according to the various specialties, with general practitioners on a geographical basis. The Medical Information Service is kept up to date by periodic mailings of information blanks to all members of the Wayne County Medical Society.

* * *

The Michigan Society of Neurology and Psychiatry held a symposium discussion on the subject of "Juvenile Delinquency" at the regular meeting of the Society in Detroit on March 16. The following members participated in the discussion: Drs. Raymond W. Waggoner, Ann Arbor—Infant, Child and the War; Gordon R. Brain, Flint—Juvenile Delinquency and Heredity; Robert H. Haskell, Northville—Racial Factors in Juvenile Delinquency; John M. Dorsey, Detroit—Juvenile Delinquency and the Home; Leo H. Bartemeier, Detroit—The Psychology of the Infant; Russell Costello, Detroit—Juvenile Delinquency and the Pediatrician; Harry J. Baker, Detroit—Juvenile Delinquency and the School; Ray H. Morter, Kalamazoo—Juvenile Delinquency and the Church; Lt. Col. Roscoe W. Cavell, MC, Detroit—Juvenile Delinquency and Neighborhood Influences; Thomas A. Gruber, Eloise—Juvenile Delinquency and the Radio, the Movies, and the Newspaper; Perry C. Robertson, Ionia—The Juvenile Criminal; Lowell S. Selling, Detroit—The Juvenile and the

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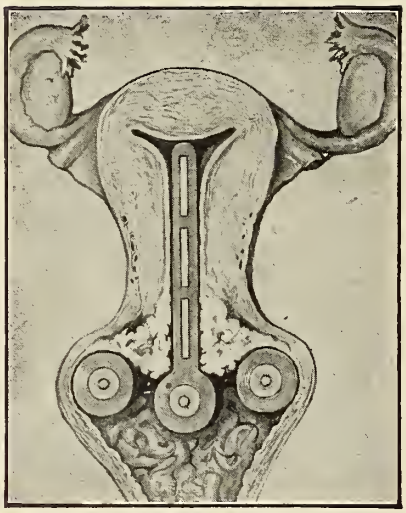
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WOMEN AND CHILDREN EMPLOYED IN MICHIGAN

Children (fourteen to eighteen years) employed in Michigan in 1940 totaled 4500; in 1943 over 100,000 are employed, 83,000 full time and the balance part time.

The number of women and children employed in 1944 will be much higher than in 1943.

It is interesting to note that twice as many children were employed in 1943 as in 1942, many being used in shops and stores.

* * *

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Individuals in the United States now have accumulated $100,000,000,000 in savings accounts. In addition, industrial plants and organizations have accumulated savings of $30,000,000,000.

It is estimated that the savings in 1944 will total $36,000,000,000.

Ninety per cent of all debts in the United States are now paid by corporations and by individuals.

The annual income for the first two years after the war will be $140,000,000,000, it is estimated. This is exactly twice as great as the annual income in 1929.

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* * *

NEW TAX LAW

Public Act 235 repeals earned income credit, freezes 1944 social security rate, increases rates on certain spirits, requires tax-exempt organizations to file returns, etc., and increases, on April 1, many rates (shown in part in the accompanying table):

Tax	Old Rate	New Rate
Admissions	1c for each 10c	1c for ea. 5c
Cabarets	5% of charge	30% of charge
Club dues	11% of charge	20% of charge
Initiation fee	11% of charge	20% of charge
Jewelry*	10% retail pr.	20% retail pr.
Furs	10% retail pr.	20% retail pr.
Toiletries	10% retail pr.	20% retail pr.
Passenger fares	10% of charge	15% of charge
Seats & berths	10% of charge	15% of charge
Light bulbs	5% mfg. price	20% mfg. pr.
Long dist. calls	20% of charge	25% of charge
Telegrams, etc.	15% of charge	25% of charge
Local phone	10% of charge	15% of charge
Pool tables	$10 per yr. ea.	$20 per yr. ea.
Bowling alleys	$10 per yr. ea	$20 per yr. ea.
Luggage, etc.	10% mfg. pr.	20% retail pr.
Local 1st class mail	2c an ounce	3c an ounce
Airmail	6c per ounce	8c per ounce
Money order fee		increased 66⅔%
Registry fees		increased 33⅓%
Insured mail		increased 100%
C.O.D. fees		increased 100%
4th class mail (parcel post)	increased by 3% or 1c, whichever is greater.	

*Except watches up to $65 and alarm clocks to $5.00

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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

MINOR SURGERY. By Frederick Christopher, S.D., M.D., F.A.C.S., Associate Professor of Surgery at Northwestern University Medical School, Chicago; Chief Surgeon at the Evanston (Ill.) Hospital. Fifth Edition, Reset. 1,006 pages with 575 illustrations. Philadelphia & London: W. B. Saunders Company, 1944. Price $10.00.

This is an enlarged fifth edition of an already proven surgical textbook. It is designed to guide the practitioner through every conceivable minor surgical emergency, and deals with all the commoner fractures and industrial injuries as well. The first four chapters on wounds, wound healing, infections and burns are particularly good, and now include the latest treatment with the sulfonamides and newer preparations. The treatment routines established by the surgeon-general and the medical research council for the military services are outlined for the care of wounds and burns.

A new chapter deals with preoperative and postoperative care, including the treatment of shock, use of blood plasma, the treatment of dehydration and vitamin deficiencies, and an adequate discussion of the treatment of surgical situations which arise as the result of disturbed blood chemistry before and after operation.

Recent trends in fracture treatment are emphasized, including "paratrooper fracture." The chapter on the treatment of varicose veins and peripheral vascular diseases has been enlarged and excellent illustrations added. The author has a most comprehensive list of references on each topic, which makes this book an ideal guide to further study.

An excellent text to read from cover to cover.

HUMAN CONSTITUTION IN CLINICAL MEDICINE. By George Draper, M.D., Associate Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University; Associate Attending Physician, Presbyterian Hospital, New York City; C. W. Dupertuis, Ph.D., Physical Anthropologist, Constitution Clinic, Presbyterian Hospital, New York City; and J. L. Caughey, Jr., M.D., Med.Sci.D., Associate in Medicine, College of Physicians and Surgeons, Columbia University. New York and London: Paul B. Hoeber, Inc., Medical Department of Harper & Brothers, 1944.

A complete and satisfactory diagnosis involves studies of the patient that must include a complete understanding of that patient's constitution, heredity, environment, past medical history. In fact the patient's reaction to stresses and outside influences as they apply to the various organs or functions of the body. This book is an attempt to point out the vast survey that is made by the successful physician, giving some of the clinical applications of the many observations on genetics, androgeny, anthropometry, somatotypes, physiology. All these things influence the reactions of the patient to outward and inward stimuli, and it is the part of the experienced doctor to properly interpret and evaluate them. The book is very interesting, and attempts to point the way of the author's thesis, giving numerous examples, in an attempt to understand "the man within the patient."

Say you saw it in the Journal of the Michigan State Medical Society

CANCER, A MANUAL FOR PHYSICIANS. By the Committee on Cancer of the Michigan State Medical Society, and the Michigan Department of Health. Lansing: The Michigan State Medical Society, 1944.

When this book first came off the press we had an opportunity to mention it editorially. There has now been time to evaluate it and the impression of the first few hours is sustained. The work is truly outstanding, as evidenced by the many calls from out of the state for copies. There are forty-four chapters averaging about five pages, including a study of the historical appearance and recognition of cancer, discussions of the nature, causes, classification, research, behavior, biopsy, etc., after which cancer in various parts and systems is considered. The following physicians and surgeons have contributed: John Alexander, C. E. Badgley, D. H. Bellinger (D.D.S.), Lawrence Berman, R. S. Breakey, W. J. Butler, J. H. Cobame, F. A. Coller, B. R. Corbus, A. S. Crawford, R. H. Cummings, C. E. DeMay, L. S. Fallis, A. C. Furstenberg, C. K. Hasley, W. A. Hyland, A. H. Kretchmar, N. R. Kretzschmar (Deceased), Isadore Lampe, K. E. Markuson, R. D. McClure, N. F. Miller, J. K. Ormond, R. J. Parsons, Grover C. Pemberthy, H. W. Plaggemeyer, H. M. Pollard, J. H. Pratt, H. K. Ransom, F. L. Rector, J. M. Robb, H. C. Saltzten, H. J. VandenBerg, E. C. Van der Heide, R. C. Wanstrom, C. N. Weller, C. V. Weller, W. W. Zuelzer and A. B. McGraw. This list speaks for the authenticity of the material presented. The book has been distributed to our members, and we urge careful study of it. It is the last word in cancer information and treatment.

APPLIED DIETETICS, The Planning and Teaching of Normal and Therapeutic Diets. By Francis Stern, Chief of Frances Stern Food Clinic, The Boston Dispensary, Assistant in Medicine, Tufts College Medical School, etc. Second Edition. Baltimore: The Williams & Wilkins Company, 1943. Price $4.00

This is largely a teachers' manual about nutrition and the scientific formations of various diets for different purposes, therapeutic and other. It is crowded with tables of information, values, contents of various elements of diet in the several foods, and numerous diet outlines for the normal person, the obese, the diabetic, the allergic; also for spastic constipation, colitis, ulcer, liver disorder, and ketogenic diet, nephritis, pregnancy. It is a valuable reference book for the busy doctor.

ORAL PATHOLOGY, A Historical, Roentgenological, and Clinical Study of the Diseases of the Teeth, Jaws, and Mouth. By Kurt H. Thoma, D.M.D., Professor of Oral Surgery and Brackett Professor of Oral Pathology, Harvard University; Oral Surgeon and Chief of Dental Service, Massachusetts General Hospital, etc., Second Edition. With 1,388 Illustrations, Including 128 in Color. St. Louis: The C. V. Mosby Company, 1944. Price $15.00.

A second edition in so few years speaks well for the excellence of this work.

This edition has been reviewed and brought up to date by including some of the rarer diseases that were omitted in the first. This volume is a complete text on all sorts of disease of the mouth, teeth, jaws, and is of primary interest to the oral surgeon and dental practitioner. It is a valuable reference for the medical man interested in diseases of this region, and should be

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available for study. The nose and throat practitioner will find it of especial value and help. It is replete with pictures and descriptions of tumors and diseases of the oral cavity, giving the pathogenesis, clinical findings and histopathology. There is no small type, the book is easily readable, and the illustrations adequate.

SYNOPSIS OF OBSTETRICS. By Jennings C. Litzenberg, B.Sc., M.D., F.A.C.S., Professor Emeritus of Obstetrics and Gynecology, University of Minnesota Medical School. With 157 Illustrations Including 5 in Color. Second Edition. St. Louis: The C. V. Mosby Company, 1943. Price $5.00.

Professor Litzenberg has condensed into very small space a world of information and instruction on the subject. This manual is very complete, practical and printed in large type for easy reading. The style is clear, the descriptions full and logical and the illustrations very helpful. This book while small and compact is fully adequate and will fit into any obstetrician's handbag, so as to be always at hand when needed.

GASTROENTEROLOGY (In Three Volumes). Volume II, By Henry L. Bockus, M.D., Professor of Gastroenterology, University of Pennsylvania Graduate School of Medicine, and Colleagues at University of Pennsylvania Graduate School of Medicine. The Small and Large Intestine and Peritoneum Diagnosis and Treatment of Disorders of the Small Intestine, Colon, Peritoneum, Mesentary and Omentum. Fully Illustrated, Including Many in Colors. Philadelphia and London: W. B. Saunders Company, 1944. Price, three volumes, $35.00.

Volume II of this set is just as outstanding as the first volume which was reviewed in these pages recently. The text is made up from the experiences of the author's associates in the University of Pennsylvania Graduate School of Medicine, and covers approximately a thousand pages. This set might well grace the library of any practitioner to his credit and great advantage, and is a must for the Gastroenterologist and the abdominal surgeon. We like this volume as well as the first.

FUNDAMENTAL EXERCISES for Physical Fitness. By Claire Colestock, A.B., M.A., Assistant Director of Physical Education, City Schools, Pasadena, California; and Charles Leroy Lowman, M.D., F.A.C.S., Chief of Staff, Orthopedic Hospital, Los Angeles, California. New York: A. S. Barnes and Company, 1943.

MEDICAL PHYSICS. Editor in Chief, Otto Glasser, Ph.D., Head, Department of Biophysics, Cleveland Clinic Foundation; Professor of Biophysics, Frank E. Bunts Educational Institute; Consulting Biophysicist, University Hospitals of Cleveland. Chicago: The Year Book Publishers, Inc., 1944. Price $18.00.

From a long list of Associate Editors Dr. Glasser has secured well written and authentic articles giving the complete study of every kind of physical reaction or procedure that has to do with medicine. Every branch of medicine is covered, from anatomy and bacteriology to surgery and urology. Every subject is given, from capillary circulation to tissue culture, from disinfection to virus studies, from air conditioning and heating in surgery to special methods in urology. The book is in large pages with two columns, approximately the size of the *Journal AMA*. Audiometers take fourteen pages and the article is entirely up to date with the very latest interpretations. Color vision tests take 18 pages,

and is one of the best treatises on the subject we have seen. Cosmic rays, bioelectricity, the electron microscope, photography, photometry, visual adaptation are a few of the subjects given marked attention. Roentgen cinematography, roentgenography and roentgen therapy take a hundred and fifty pages. Every article we have read goes into minute detail in the scientific exposition of the subject. A medical man who is a student of science, or interested in the many processes in the science of physics that he uses every day must be interested in this book. It brings between two covers literally a world of material the assembling of which would be a monumental task.

SAFE CONVOY, The Expectant Mother's Handbook. By William J. Carrington, A.B., M.D., F.A.C.S., Attending Gynecologist Atlantic City Hospital, Atlantic County Hospital for Nervous and Mental Diseases; Diplomate American Board of Obstetrics and Gynecology, Formerly Vice President American Medical Association. Philadelphia and New York: J. B. Lippincott Company, 1944. Price $2.50.

To a prospective mother this book will prove a guide to healthier and happier months ahead, as well as a well ordered family life after the great event. Just the right kind of advice is given that will prove the most useful. Diet, vitamins, complications are made understandable to the prospective mother. There are also chapters on the feeding of the baby, and his care, also one on fatherhood that is worth reading. We think this an exceptionally good book to place in the hands of the young expectant parents.

HANDBOOK OF NUTRITION, A Symposium Prepared Under the Auspices of the Council on Foods and Nutrition of the American Medical Association. Chicago: American Medical Association, 1943.

The Council on Foods and Nutrition has gathered in this book many articles from the pages of the *American Medical Association Journal* bearing upon foods, values, nutrition, calories, iron, iodine, vitamins. Common and unusual foods are described with their composition, tables of caloric values as purchased, with an estimate of amount of waste. There are articles on feeding of the infant, children and the aged; the nutritive requirements in pregnancy and lactation, and the adequacy of American diets. These are all gathered in a convenient form, readily referred to, and authoritative.

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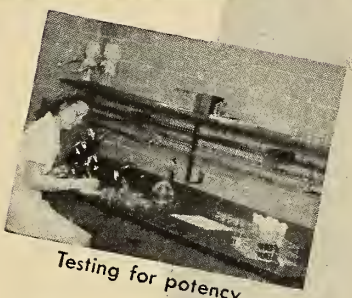
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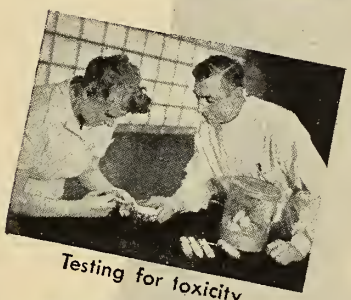
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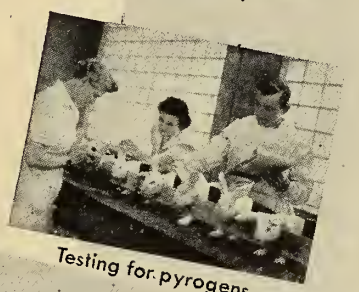
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A MALARIA MOSQUITO SURVEY OF SOUTHERN MICHIGAN

CURTIS W. SABROSKY
Michigan State College

Michigan, although a highly malarial state in pioneer times, is scarcely given second thought in present-day discussions of malaria. It will average seventy to ninety endemic cases per year for the entire state, with occasional cases recorded in the Upper Peninsula.

Several recent trends have directed greater attention to the problem. Among these are the return of military personnel invalided home because of malaria, the influx in considerable numbers of southern laborers, and congested living conditions in war-swollen industrial areas leading to the rise of trailer camps and generally poorer protection against mosquitoes. With this background, it was highly desirable to investigate the malaria mosquito fauna of the state and to determine the extent and intensity of the Anopheline problem. Hence, in the summer of 1943, a mosquito survey of the southern and most populous portion of the state was carried out by the writer under the auspices of the Michigan Department of Health and Michigan State College. A detailed report of the survey is now in preparation as a technical bulletin from the latter institution. The present note will serve to make immediately available the general results of the season's work.

The survey extended from late July to early September and covered 4,512 miles in 31 counties, all located south of a line drawn from Muskegon through Midland and Saginaw Bay. A total of 660 stations were sampled, with a recorded total of 7,276 larvæ and pupæ, and uncounted thousands of adults, of which 4,907 larvæ-pupæ and 951 adults were brought to the laboratory and identified.

It was already known that there were only four species of *Anopheles* to consider in Michigan: *quadrimaculatus, punctipennis, walkeri,* and *occidentalis* (= *maculipennis* of authors, in part). Only a few adults of the last-named species were taken in the area covered, at several places in Midland and Tuscola Counties near the northern limits of the survey. Practically speaking, only three species occur in the region in significant numbers.

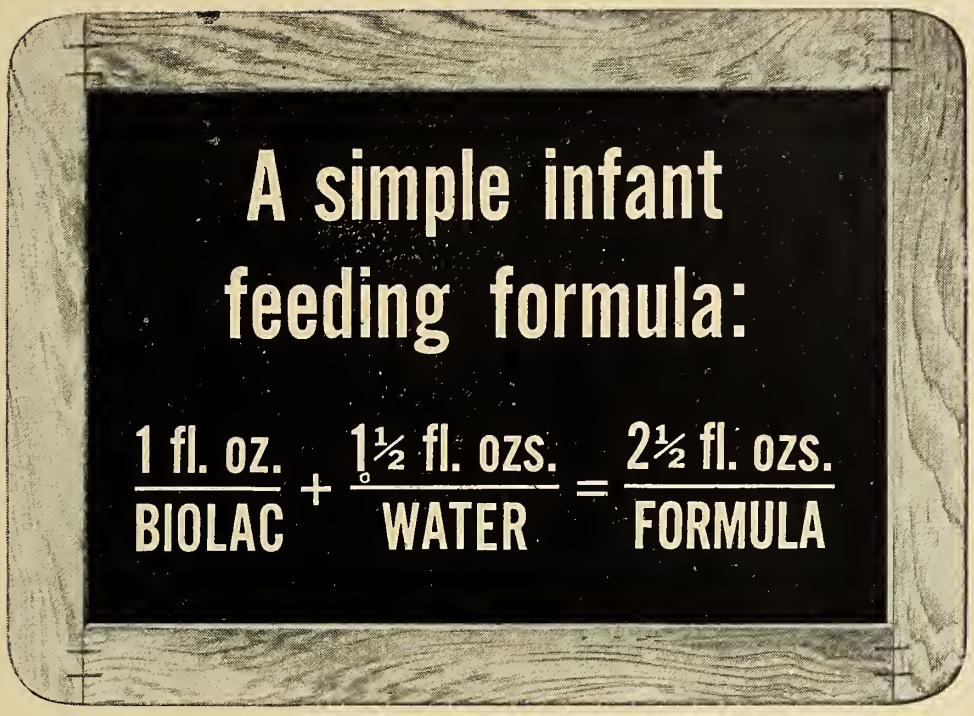
Anopheles mosquitoes were found to be abundant and widely distributed in the area. Of the 660 stations, 624 were sampled for larvæ, and of these 419 or approximately two-thirds (67.1 per cent) were found to be breeding *Anopheles*. A total of 7,276 larvæ and pupæ were recorded, an average of 17.36 per station. Adults were sampled only incidentally, but a total of 951 were actually identified. On occasion, estimates in the field ranged as high as 8,000 at a single location, which was the conservative calculation for *A. quadrimaculatus* resting on the privy at a boys' camp.

One striking feature of the survey was the great abundance of *Anopheles quadrimaculatus,* the most important vector of malaria in eastern United States. It was breeding in 352 or 84 per cent of the 419 stations where *Anopheles* were found. Of the 4,907 larvæ brought into the laboratory and identified (the balance of the 7,276 represents a field count of first-instar larvæ), 3,685 or 75.09 per cent proved to be *quadrimaculatus. Punctipennis* and *walkeri* shared the remainder with 19.97 per cent and 4.94 per cent, respectively. For various reasons, it is considered unlikely that the true proportion of *quadrimaculatus* in nature is anywhere near as great as that. Nevertheless, this high percentage, and the fact that it was represented in 84 per cent of the positive stations, plus the large numbers taken in the adult survey, can only mean that it is a common and important factor in the mosquito fauna of the state. This is contrary to the belief in some quarters, that inasmuch as Michigan appears on published maps to be the northern limit of its range, it would be found here rather sparingly.

A second important fact established by the survey is that *quadrimaculatus* in Michigan is often found in combination with the other species. At over one quarter of the positive stations (110 or 26.2 per cent), there were two species of *Anopheles* breeding in the same habitat, one of them being *quadrimaculatus.* Rarely (6 stations), all three species were present. Expressed in terms of the 352 stations where *quadrimaculatus* larvæ were recorded, the species was the sole Anopheline in two-thirds (67.04 per cent) of the cases where it occurred, and in one-third (32.9 per cent) it was associated with either *punctipennis* or *walkeri,* or rarely both.

When the data were analyzed according to type of breeding place, a third major point was evident, at least for Michigan conditions, namely that *quadrimaculatus* breeds in some numbers in running waters which would not ordinarily be considered suitable. Of the 419 stations where *Anopheles* were found, 286 were classified as standing water (marshes, ponds, lake margins, old creek channels, etc.) and 133 as running water (rivers, creeks, drainage ditches, et cetera). As might be expected, 91.6 per cent of the former stations produced *quadrimaculatus,* with an average of 11.2 identified larvæ per station. Of the latter, two-thirds (67.6 per cent) of the stations had *quadrimacula-*

(Continued on Page 460)



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SOCIALISM AND NATIONAL WELFARE

CLAUDE R. KEYPORT, M.D.
Grayling, Michigan

We are living in a changing world. This global war is making many changes and what the postwar period will do, or how it will change the present status of American Medicine, is anybody's guess.

Recently in an address before the Economic Club in Detroit, Dr. Ruthven, President of the University of Michigan, made this statement: "They who anticipate a return of the prewar world conditions are fated to be classified with those who throughout all history have stood ineffectively against social changes through their inability to read handwritings on the wall." What does this mean?

Life goes in cycles and just so, government goes in cycles. For years we have been leading up to the thing which now is beginning to alarm us, namely, the gradual encroachment of government in medicine. We have been asking for it. We have unconsciously been asking county government, state government, and finally, federal government to assume part or all of the financial load of caring for certain specified groups of people and certain types of illness, and as government has met our requests, this can only be interpreted as socialism.

Probably few people realize that this socialism has been under way ever since the dawn of the Christian era, and is already far advanced. The real question is, how much farther should socialism go in the interest of national welfare? In 1942, 97 per cent of the beds in mental hospitals and 85 per cent of those in tuberculosis sanatoria were in government hospitals; 48 per cent of the beds in general and special hospitals for acute disease were under some kind of government control in state, county or city.

By January 31, 1942, a fifth of all physicians in nonmilitary service held salaried positions: 7,216 in teaching positions, research, executive positions and industry; 9,819 in government service; 16,457 in hospital service (Journal AMA, June 20, 1942). Add to these, 45,000 or so brought into the armed forces since Pearl Harbor (exact figure is a military secret) and you may have between 30 and 45 per cent of our 176,000 physicians on salary depending on the percentage of those in the armed forces who were drawn from private practice.

President Roosevelt, in both his annual message to Congress on January 11, 1944, and in his budget message of January 13, urged the legislators to explore the possibility of a broad amendment to the Social Security Act. The people's supreme postwar objective, he said, is security in every essential economic, social and political sense. Without security, he declared, individual freedom cannot exist.

The President voiced the view that in the development of the nation there has emerged a bill of individual economic rights which supplements the constitutional bill of rights. These economic rights were described as including the right of everyone to have adequate medical care. Directly on Congress rests the responsibility of implementing the bill of economic rights, Mr. Roosevelt asserted. Legislation for that purpose was already before the House and Senate, he reminded his listeners (referring apparently to the Wagner-Murray-Dingell proposals among others).

A few days after the Chief Executive divested himself of these views, Mrs. Roosevelt added hers. Said she in her column, "My Day" that the draft showed our failures where health is concerned. The low-income groups can afford neither medical care, nor a proper diet. Nor can they afford decent clothing and housing. All of this contributes to lower health standards. Mrs. Roosevelt concluded by viewing with alarm, "the fact that we have no nation-wide social insurance measures to protect American families against disabilities and sickness."

In full agreement with the First Lady is Arthur J. Altmeyer, chairman of the Social Security Board, whose eighth annual report was made public on January 17, 1944. The Board urged a stronger and more comprehensive program of social security for the nation, including insurance to cover the costs of hospital and medical care. It added that "Lack of adequate measures to cope with sickness and disability represents the most serious gap in provisions for social security."

While the Chief Executive and various pressure

(Continued on Page 460)

Extract of a paper delivered by President Keyport before the Saginaw County Medical Society, Saginaw, Michigan, April 18, 1944.

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SOCIALISM AND NATIONAL WELFARE

(Continued from Page 458)

groups were and are suggesting and urging more socialization in medicine, and while labor groups are asking for more security, believing that they would be getting something for nothing, we have had one of the best examples of a bureaucratic form of government thrust upon us. I refer to the Emergency Maternal and Infant Care program. This is definitely an entering wedge in the social program. It is being advertised by the U. S. Department of Labor. The following was released for Sunday papers, March 19, 1944:

"A quarter of a million wives and babies of servicemen have received or are receiving care under the Emergency Maternity and Infant Care Program, Katherine F. Lenroot, Chief of the Children's Bureau of the U. S. Department of Labor, announced today on the the occasion of the first anniversary of this program. In February, more than 36,000 applications were approved, the largest number to date for any one month.

"The program is now in operation in all the States, the District of Columbia, Hawaii, and Puerto Rico. Considering the difficulties of establishing any nationwide program, Miss Lenroot said, something of a record has been set in this instance. Hardship undoubtedly resulted in many cases when servicemen's wives found themselves living in States where the care was not available. Now the last of the States have their program in operation.

"Congress to date has appropriated $24,200,000 to extend to July 1 of this year, to provide hospital and medical care without cost to servicemen's wives during pregnancy, childbirth and for six weeks after the baby is born, and for the infant the first year. Families of men in the four lowest pay grades are eligible. The funds are administered by the Children's Bureau through State health departments."

From these quoted facts it is quite evident that political groups are most interested in expanding their power—and the people seem to forget the wise words of Winston Churchill who said: "We must beware of trying to build a society in which nobody counts for anything except a politician or an official, a society whose enterprise gains no reward and thrift no privileges."

Registration Under the Harrison Narcotic Act.—Physicians, other than those in the Armed Forces, who are registered under the Harrison Narcotic Act or under the Marihuana Tax Act must effect re-registration on or before July 1 to avoid a penalty. (See *JAMA,* June 3, p. 357.)

National Wartime Graduate Medical Meeting Committee invites you to its Second Michigan Clinic Day, at Fort Custer Station Hospital on Wednesday, June 21, 1 p.m. to 6 p.m., followed by a picnic supper at Eagle Lake, Station Hospital grounds.

COUNCIL AND COMMITTEE MEETINGS

Executive Committee of The Council—Olds Hotel, Lansing, February 24.

Executive Committee of The Council—Olds Hotel Lansing, March 23.

Procurement and Assignment Service Committee—Statler Hotel, Detroit, March 23.

Maternal Health Committee, University Hospital—Ann Arbor, April 5.

Executive Committee of The Council—Statler Hotel, Detroit, April 20.

Joint Committee MSMS-State Bar—Olds Hotel, Lansing, April 23.

MSMS Venereal Disease Control Committee—Olds Hotel, Lansing, April 23.

Mental Hygiene Committee—David Whitney House, Detroit, April 27.

Postgraduate Medical Education Committee—Statler Hotel, Detroit, May 3.

Procurement and Assignment Service Committee—Statler Hotel, Detroit, May 11.

Ethics Committee—Hayes Hotel, Jackson, May 14.

Cancer Committee—Woman's League, Ann Arbor, May 23.

Executive Committee of The Council—Statler Hotel, Detroit, May 24.

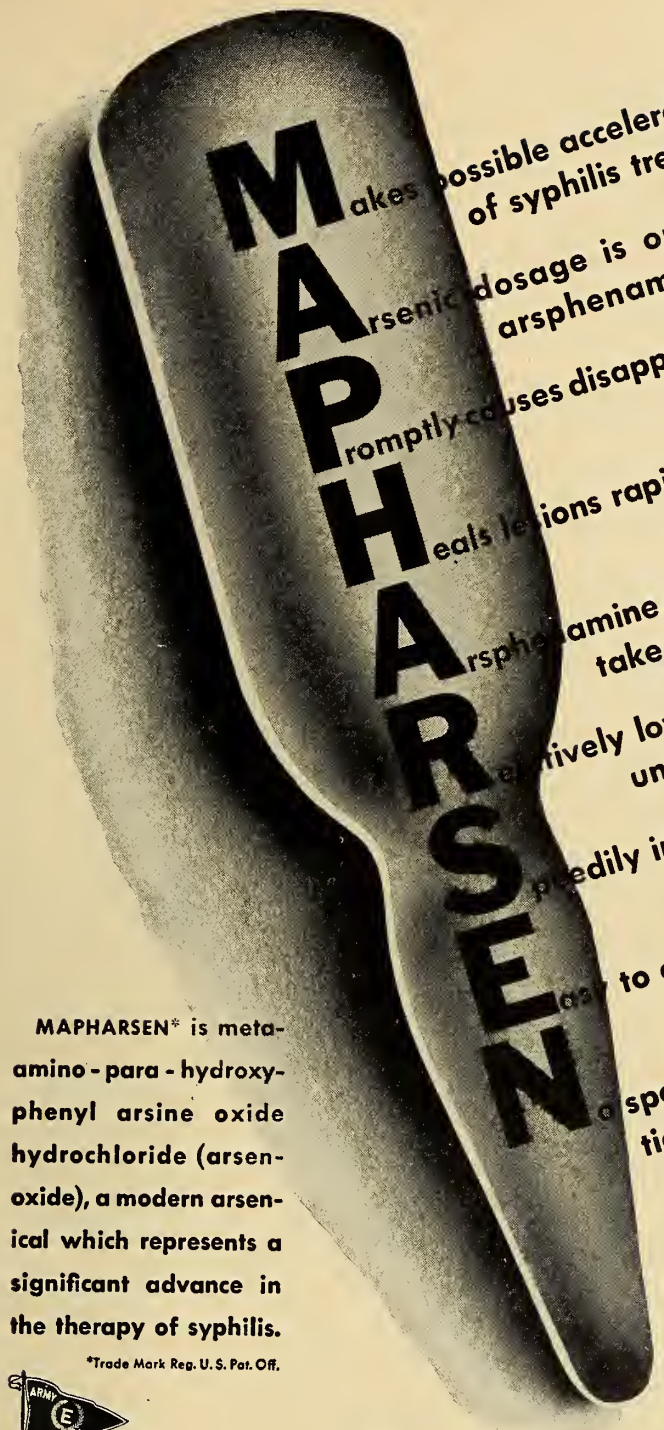
A MALARIA MOSQUITO SURVEY OF SOUTHERN MICHIGAN

(Continued from Page 456)

tus, with an average of 8.1 identified larvæ per station. The important fact is not the smaller proportion of the second type, but the fact that so large a proportion of running water habitats did produce *quadrimaculatus.*

It is often stated that *punctipennis* is likely to be found in running waters and the data show that the species occurred in 63.9 per cent of the running water hibitats, but only in 16.1 per cent of standing water types. This appears to be a rather significant difference Another angle should also be noted, however, for even though *punctipennis* shows strong preference for running waters, still it was actually collected in fewer stations in such places than was *quadrimaculatus* (63.9 per cent as against 67.6 per cent for the latter).

In brief, it can only be concluded from such data that southern Michigan has a tremendous Anopheline population whose significant size has not hitherto been appreciated; that *Anopheles* mosquitoes are abundant and widely distributed by virtue of the state's great extent and frequency of lakes, marshes, pond holes, et cetera, and the miles and miles of drainage ditches and streams of all sizes; and that *Anopheles quadrimaculatus,* the most dangerous malaria vector of the eastern United States, is the most important and most frequently encountered Anopheline mosquito in the area. While not a cause for hysteria, it is, nevertheless, esential that the full import of the data be realized in a consideration of the malaria problem in relation to such matters of public health as were cited in the introduction.



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FEDERAL SUBSIDIES

The real beginning of Federal subsidy legislation was the Morrill Act in 1857, establishing the system of land grant agricultural colleges. This was followed by other agricultural bills, and in 1916 Federal aid moved into the highway field and in 1918 into public health. In 1935, the program bloomed under the Social Security program.

A brief summary of the more important Federal aids follows:

Public Health, assisting states, counties and health districts to establish and maintain adequate public health services and personnel. Annual appropriation, $11 million. No state matching appropriation required.

Veneral Disease Control, begun in 1918 and amended in 1935. 1942 appropriation, $7,817,000, with grants matched 100 per cent.

Child Welfare, begun in 1935 to establish the Children's Bureau to coöperate with state public welfare agencies for the care of homeless, dependent or neglected children. The authorization is $1,510,000 annually. No matching state appropriation required.

Crippled Children Services, begun in 1935 to enable states to extend and improve service for crippled children, providing medical, surgical care. Authorization is $3,870,000 annually. Matching state appropriation of 100 per cent usually required.

Maternal and Child Health, established 1935 to permit states to extend and improve services protecting health of mothers and children, particularly in rural or economically affected areas. Annual authorization, $5,820,000. Matching state appropriation of 70 per cent to 100 per cent required.

Federal Public Housing Authority, provides for contributions to housing agencies to assist in achieving and maintaining low rent character of their housing projects. Annual contributions of $28,000,000 are authorized; annual obligations now running about $10,500,000. The receiving agency is required to contribute in tax remissions, tax exemptions or cash by at least 20 per cent of the amount of the Authority grant.

The Social Security Act of 1935—Old Age Assistance, provides aid to states in furnishing assistance to aged, needy individuals. Expenditures rose from $124.6 million in 1937, to an estimated $329 million in 1943. In general, the Federal grant is 50 per cent of the cost.

Aid to Dependent Children, to enable each state to furnish financial assistance to needy dependent children. 1943 estimated expenditures are $78 million. Grants are made on a 50 per cent basis within prescribed limits.

Aid to the Blind, to aid states in providing financial assistance to the blind. Estimated expenditures for 1943 are $8.7 million. Grants to be matched 50 per cent within limits.

The United States Employment Service, first established in 1933 on a state participating basis. Now an exclusive Federal activity under the War Manpower Commission.

Unemployment Compensation State Administration, provides authorization of $80 million each fiscal year for grants to states, although the Federal share of unemployment taxes runs more than $125 million a year.

Federal Aid Highways, includes the Federal Aid Road Act to provide a national highway system; Secondary or Feeder Roads, first provided for in 1933; Grade Crossing Elimination, established 1933; and Public Lands Highways, established 1921. These cover various projects indicated by their titles. Involves authorization of $141 million annually with various degrees of matching appropriations.

Miscellaneous: This group includes Forest Planting Stock; Forest Fire Coöperation; Wildlife Restoration; State Homes for Soldiers and Sailors, and State Marine Schools. Authorizations vary according to type of project; matching appropriation required in varying degrees. Not all states participate.

The trend of Federal Aid may best be considered by observing the patterns into which the types of aid fall. Prior to the depression, Federal payments to the states never reached an annual total of more than $200,000,000, and the following table reflects the historical trend:

	Millions
1917	$ 13.6
1922	124.3
1927	134.1
1932	264.7
1937	393.7
1942	693.9

With Federal money goes Federal control, the conditions and limitations on states increased and strengthened with each new grant, with the result that Federal Bureau chiefs now excise a veto over many state activities. The resulting rupture between national fiscal control and our original political forms based on state independence has resulted in a deterioration of the latter, with Federal "leverage" on the states introducing a factor which the states to date have not circumvented.—*Michigan Public Expenditures Survey, Detroit.*

Circular operating rooms at the Marinette General Hospital utilize space to the best advantage and have proved very satisfactory in operations. The two major rooms are 18 feet in diameter, the minor ones, 15 feet —*Hospitals,* April, 1944.

Table of Contents

The Problem of the Mild Psychoneurotic in the Army.
Colonel Walter B. Martin, MC, and *Lt. Colonel Paul A. Petree, M.D.* 483

Postpartum Sterilization.
Edward A. Schumann, M.D. 488

Edema in Children.
Irvine McQuarrie, M.D. 492

Office Treatment of Rectal Disease.
Andrew E. Souda, M.D. 501

President's Page.
Billions and Bureaus 505

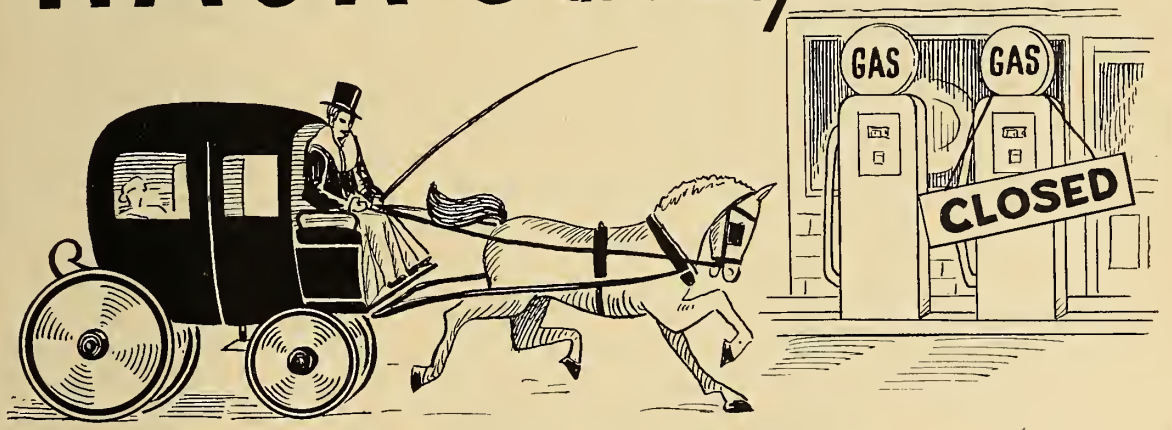
Editorial:
Pays 20 Per Cent Proration 506
Fifth War Loan 506
The Bureaucrats 507
Physical Medicine 507

You and Your Business 510
In Memoriam 514
County and Personal Activities 516
The Doctor's Library 524
Supplemental Roster 526

War Medicine:
A Malaria Mosquito Survey of Southern Michigan.
Curtis W. Sabrosky 456

Socialism and National Welfare 458
Federal Subsidies 462

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The Problem of the Mild Psychoneurotic in the Army

By Colonel Walter B. Martin, MC
and
Lt. Colonel Paul A. Petree, MC
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The men in the armed forces represent a cross section of our population and are the product of various hereditary and environmental conditions. In the Army they must conform to a way of life that carries with it regimentation, fatigue, discomfort and hazard to life. A strong emotional drive acting within and without as exemplified by group loyalty and patriotism or an intelligent sympathetic consideration of their problem by medical officers may aid them in making an adjustment. In general, they are not soldier material and can serve more effectively in civil life since under strain they develop multiple functional complaints that destroy their usefulness as soldiers.

In considering the problem of the mild psychoneurotic, it might well to point out that the term "mild" does not refer to the degree of severity of the manifestations in these cases but rather to their relative stability and the weight of the load that is required to upset their equilibrium.

The men that make up an army brought together as ours has been, by drawing on our total manpower in certain age groups, represent a cross section of our population—the strong and the weak, the industrious and the indolent, the skilled and the unskilled, the courageous and the cowardly, the stable and the unstable. They are the product of their heritage and their environment. They are idealistic, self-seeking, patriotic, indifferent, group conscious and egocentric, according to their social, moral, or religious background. They come from the shops, the farms, the slums and the universities. They have the outlook, prejudices and traditions of numerous races and creeds and of various political philosophies. In the army they must adjust to a general pattern. They must sink their personalities in the unit they serve. The course of their life is suddenly altered. Separated from the security of their home and familiar social environment, they must create a new life under strange conditions. Freedom of action is lost. No longer are excuses for delinquencies listened to by sympathetic ears. Even their identity is submerged and their serial numbers become more important than their names.

It is obvious that much of this material is not the stuff from which soldiers are made. The physically unfit must be excluded and, with even greater care must those with unstable personalities be weeded out. The local boards and induction boards have screened out thousands of these individuals but other thousands have slipped through the net and now present one of the major problems of the army. Thousands of them are

Read at the third Postgraduate Conference on War Medicine, the Seventy-eighth Annual Session of the Michigan State Medical Society, Detroit, September 27, 1943.

being discharged and now or later will be a problem of civil life. For the most part they are not the product of army life or combat service. They were basically unfit when they entered the army and totally unable, due to personality defects, to adjust to army life or meet the strains inherent in the performance of the duties of a soldier. We are particularly concerned today with the milder group since this group is less often recognized in civil life and often in the protected and narrow groove in which they live encounter no serious difficulty and, if returned to their former environment, may adjust themselves again. On what basis are we to judge these individuals, how are they to be handled in the army and what is to be their fate afterwards?

There are two classes of mental disorders. There are those due directly to organic lesions and those which have no demonstrable structural change. Psychoneurosis falls in the functional group. It is a non-volitional combination of clinical symptoms based on anxiety, fear, compulsion, obsession and conversion phenomenon. In war this syndrome is largely a defense mechanism resulting from a desire to preserve one's life, security or social habits and, at the same time, lose nothing of the regard or respect of one's fellows. It is essentially an alibi mechanism. It is believed that this is accomplished through the operation of the subconscious mind although at times it is difficult to separate the conscious and willful malingerer from the true psychoneurotic, in fact, some believe there is no line of demarcation. Its name implies both psychological and physiological components and the disorder is reflected in both psychological and physiological symptoms. It differs from the graver psychological disorders, Dementia Praecox and Manic Depressive Psychosis in that it is only a partial reaction and disrupts only a portion of the functions of the mind, the personality is less disturbed, the emotions remain relatively pliable and insight and judgment are better retained. One suffering from psychoneurosis is able to make an objective examination of himself and evaluate his disorder, although he may not be able to do anything about it.

As their emotional feelings and instinctual drives tend to express themselves they encounter the criticism of the outside world, morals and conscience and the channelizing forces of environment. They do not care to undergo modification or change their direction. These urges are primitive and crude, know no laws, no logic or values, no good or evil, no morals. The pleasure principle reigns supreme. They cannot be destroyed any more than physical matter can be destroyed. If they are strong, as are the instincts of self-preservation in time of war, and moral obligations and draft boards rush them to the battlefront, the impact results in conflict and complexes to be fought out in the subconscious mind. The processes of disguising, compromising or resolving these difficulties are spoken of as mental mechanisms. They are clever but they are weak. The turmoil created by this conflict is the disease itself. Our reactions to these various impasses or divergent tendencies, how we feel about them, what we think about them and what we do about them, expressed in words or conduct through motor or sensory means, in symbolic form or tension states, are the symptoms per se of the psychoneuroses. They are often so disguised and dramatized as to fascinate the patient himself and arouse the sympathy of others. In a well-balanced person these driving forces are surrounded by protective forces and he is able to resolve, repress or effect a compromise, whereas in the psychoneurotic these conflicts are resolved by conversion into functional symptoms which he believes will allow him to follow his basic impulses and yet escape the consequences.

It is the belief of the psychiatrist that probably eighty per cent of all psychopathological disorders developing in adults are based on the persistence of the immature emotional reactions of childhood. The doting parent who fondly hopes to prepare a child for life by affording it protection against all childhood stresses and strains is only fostering a weakling incapable in later years of meeting the responsibilities of adult life. The precept of the ancient Medes that boys should be taught to ride, to shoot and to tell the truth, has much to commend it. The following case will illustrate this point:

Private W. C. D. was admitted to Percy Jones General Hospital March 29, 1943, with an anxiety type of neurosis. He told of adjusting very well in the army until he witnessed his buddy in the same fox-hole being blown to bits and of watching the wounded suffering for hours before they died. In talking with his

mother, she became upset and cried and presented photographs of her boy from babyhood through his senior year in college, depicting him as a serene young man and relating how she had always tried to protect him and taught him never to smoke or drink. She said he had occasionally gone to church with a girl in a group but never alone and that he had never been permitted to take extracurricular work in school because she was afraid he would overexert himself. His teacher wrote that she felt sorry for him because his mother would come and sit in school with him and not permit him to engage in strenuous games or play on the slide at recess for fear he would get his pants dirty. At first he was very idealistic and spoke of wishing to continue in service but after his mother's visit his condition became aggravated and it was necessary to disposition him on a Certificate of Disability.

This soldier was not only tied to his mother's apron strings but psychologically certain fetal anatomical ties had not been severed. There is no straight road over which parents may guide their children; rather, it is a steep and twisted trail which the child must learn to climb. There are certain maps and guideposts and the child's feet can be set in the path but it must do the climbing.

In contrast to this patient, we have the case of C. C. who was admitted from the same convoy, with the same diagnosis and whose trouble was precipitated by similar experiences. In developing his history it was learned that he came from a family of hardy landowners in a neighboring state. The father was energetic, thrifty, strict but kindhearted. He was proud of his several sons. He hunted and fished with them and treated them as pals. In talking with him he said, in his usual way of expressing himself, "By gosh, I tell you there ain't none of my kids that's going crazy because there ain't no crazy people in Ma's family and there ain't none in mine.' After seven days in the hospital and thirty days' furlough, this soldier was returned to duty, soon became a sergeant and our last word was that he was headed for Officer Candidate School.

How frequently do we encounter these cases in the army. In the United States they are entering the hospitals at the rate of twenty-seven per thousand per year. Mental failures are second only to battle wounds and malaria as a cause of hospitalization in combat areas. Between fifteen to twenty per cent of all casualties returning to the United States are neuropsychiatric cases and in certain theaters of war this figure has been as high as forty per cent. It is only fair to say that relatively few of these are battle reactions. Most of them should never have reached the zone of operations and many of them were hospitalized soon after debarking. There have been very few wounded psychoneurotics. This is susceptible of two explanations, namely: First, few psychoneurotics actually go into combat; second, a disabling wound may cure the psychoneurotic manifestations, since it offers the perfect crutch.

Of the total admissions to Percy Jones General Hospital, fifteen per cent are sent directly to the neuropsychiatric section and an additional twelve per cent are seen in consultation. Most of these are disposed of on a psychiatric diagnosis. These figures do not include neurosyphilis or neurological cases, or a considerable number of functional cases seen and disposed of on the gastrointestinal and cardio-vascular services.

What can be done about this matter? Fundamentally we should go back thirty years and raise a generation less coddled, less spoiled and less spoonfed, and with a greater sense of group reponsibility.

The examining boards have come in for more than their share of criticism, since the screening out process is not as easy as it appears on the surface. A few questions and a short objective examination is inadequate to determine who will make a good soldier and who will not. The severe and moderately severe cases should be easy to exclude but in civilian life the mild psychoneurotic has a greater leeway in protecting himself and may be able to carry on fairly well. If his load is too heavy he may take a day off or change jobs. He is not able to do this in the army but must become an efficient unit in his organization or be discarded. You may know him as a fairly intelligent individual who makes the rounds of the doctors' offices, with multiple vague complaints, and frequently resorts to quacks. He is overanxious, rigid, opinionated and overconcerned about his health. He is lacking in humor, often overserious, not given to sports and subject to mood swings.

Anyone who has shown neurotic traits, such as bedwetting, nail biting, night terrors or sleep walking and those who are morbidly anxious, excitable, arrogant or who show signs and symptoms of anxiety or fear, or afflicted with obsessional ideas, compulsion acts or symptoms of systemic diseases of undetermined origin, should

be immediately rejected as unsuited for the military service.

There is no place in the army for the mental defective unable to plan, calculate or construct, awkward and untidy in personal habits, who learns by precept rather than concept and is incapable of comprehending and executing complex orders. There is no place for the psychopathic individual who proceeds without definite pattern or standardized activity, who does not respond to social standards of decency or honesty. There is no place for the inebriate or the drug addict. Those individuals who find it difficult to adjust in civilian life with many avenues of escape will find it almost impossible to adjust to the routine, restrictions and regimentation of military life. They may even disrupt discipline and morale and retard progressive military training. When inducted, such a soldier sooner or later finds himself a dud in his job. The result is tragic. He is unable to pull the blinds against the exacting orders of a demanding sergeant or the critical scrutiny of his fellow soldiers. He reposes in moments of inertia but he does not sleep. Light noises strike terror into his heart and his stomach. He sits on the edge of his chair. His existence is one of jumpiness and apprehension. He is afraid to turn a corner for fear of meeting himself. On maneuvers be becomes more concerned with the cramp and pain in his rear axles and what happens to his digestion than what goes on in the army or the universe. He becomes afraid his heart will not beat or he will cease breathing and keeps a camphor bottle by his bedside.

Their patriotism may be sterling but their usefulness is negative. They are far better able to contribute at home on the farm or in defense plants. Their induction is unfair to them. They wait in line to report on sick call, many the first day after entering the service, in the hope that the army doctor will be able to help them. They occupy our hospital beds, urgently needed by others. Many from our Service Command have been in the hospital three out of four months of service, while many from overseas have been in the hospital eleven out of fourteen months of service. They become a heavy financial load and they render no useful military service. There is no place in our ships to transport them overseas and back again.

Many who succeed in civil life will fail in military life. They are unable to turn to their favorite book that makes a successful appeal to the apathy. They cannot indulge in luxuries or give vent to their prejudices. They cannot be running back from the Solomons or Guadalcanal to consult their favorite physician. They cannot stop in the drugstore for a soda or go to their club for a highball and they cannot go fishing. They are not able to secure advice from their parents or their friends who may lighten their burden by the balm of sympathy. They must endure the clouds of their special discomfiture which follows them like a pup and there is no escape from this sudden, unplanned turn in their lives.

Strange people knock on the entrance gates to the army. People with queer skills, and odder personalities—acrobats from the circus, hardy youths from the mills and farms, people just young, flush with money, heady, rebellious, self-indulgent and with a temperament and a sense that "war is a moral outrage." Some exhibit brazenness rather than breeding, glibness rather than wisdom, audacity rather than forbearance. The army is scarcely an organization conducive to psychological serenity or efficient digestion. The business is hazardous and insecurities of the quivering youth who enters its gates are apt to be intensified.

The soldier must be looked upon as a type of individual requiring creative qualifications, men able to respond in an honest, truthful, decent and adult manner to his fellow associates, men able to think clearly and logically and have a tenacity of purpose, men who will conform to organized authority and cultivate responsiveness and obedience to others.

Many directives stress the fact that the "army is waging an offensive type of warfare and is not to be considered a social service or curative agency, a haven of rest for the weary, a reform school for the delinquent, a gymnasium for the weakling or a psychiatric clinic for the emotionally unstable."

Once a soldier is inducted, much responsibility rests upon the army and especially upon his immediate commanding officers. He may be made into a well trained, well disciplined and qualified soldier, contributing much to army morale and determining its success. Of greater

importance than mere numbers of men or the materials of war is their proper selection and intelligent handling. The new recruit is confused and disturbed, he has entered a strange environment away from the security of his home. He is deprived of his freedom of action and subjected to discipline but does not yet know his privileges or the careful thought that has been given to protecting him. He has lost his privacy and is thrown into mess and barracks with rude men where he hears alarming stories of the life of the new recruit. This is a difficult period of adjustment and much future trouble can be avoided by thoughtful handling of the soldier at this point. Attention should be given to his individual needs, assistance with his insurance and allotment, maintenance of communication with his family, passes, entertainment and the assurance of care of sick relatives at home. The officer who looks after his men will gain their respect, confidence and loyalty and will be rewarded by a high morale in his organization.

In seasoned troops the factors are more positive: waiting, boredom, suspense, physical strain, worries about home affairs, loss of sleep, irregular and inadequate meals and debilitating diseases, such as diarrhea or malaria.

In the actual combat zone the causes are fear of bodily danger, constant alerts, bombardments and the sight of panic and death. Fighting in small detachments, as frequently occurs in jungle warfare, the mental hazard is much greater than when masses of troops are deployed. Where small groups are cut off, frequently only a few will escape and the effect of their experience on these few may be disastrous. Man possesses a strong social nature—the herd instinct. His confidence is impaired when alone. Many soldiers returning from the Southwest Pacific will tell you that while waiting in fox-holes, if there are others about them in speaking or whispering distance, they are relatively comfortable. They not only feel more secure from danger of surprise but also from what is called "separation anxiety."

The majority of patients entering the hospital originating in the home area show conversion phenomena, neurasthenia or hypochondriasis, while those from the battle areas exhibit anxiety states and fixation phenomena referable to the gastro-intestinal tract, respiratory, cardiac or urinary systems. Their complaints vary widely with the many clinical symptoms arising. The immediate and predominant reaction from the battlefield is confusion, panic, terror, rage or a stupor-like trance state with loss of the instinct of self-preservation and volitional control. In many soldiers these terror states are short lived and there is amnesia for their experience and the soldier may continue on with his work. Certain of the soldiers that break under extraordinary strain make good progress toward recovery on returning to this country.

Later there is a gradual development of symptoms not unlike those encountered in peacetime. They may be expressed in symbolic form, paralyses, tics, hysterical blindness, aphonia or amnesia. They may be shown in nervous tension, emotional and mood states, fear, apprehension, anxiety, sudden attacks of intense restlessness, insomnia, nightmares, startle reactions, bouts of depression and thinking disturbances. They may be shown in character changes, irritability, sullenness, resentfulness and display of temper and, finally, they may be manifested by vasomotor or autonomic nervous system syndromes—headaches, faintness, dizziness, weakness, easy fatigability, sweating, cold hands and feet, palpitation of the heart, shortness of breath, jerky, jittery feelings, frequency of urination, nausea, vomiting and diarrhea.

In most instances we believe that soldiers exhibiting evidence of psychoneurosis, however mild, should be returned to civil life. In general they will do better if returned to the familiar environments of their homes. While no stigmata or disgrace should be attached to the soldier who has put forth his best effort, we are still confronted by the fact that in many instances the lack of will power to perform an undesirable or distasteful duty is the background of his failure. Before these men are discharged, each case is carefully considered by a board of medical officers who have studied all aspects of his particular case carefully. Among the other duties of this board is the fixing of the line of duty. In simple parlance, this means the determination of whether or not the government is or is not responsible for his condition. If he has become mentally disabled by reason of unusual strain and hazard of the service, then he is a responsibility of the government, otherwise he is entitled

to no special compensation, now or later, by reason of his military service. It has been a common observation that the soldiers returning from furlough are definitely worse upon their return. We strongly suspect that they have been subjected to an excessive dose of sympathy and possibly have been enticed by the allurements of the easy life and high pay of civilian employment. We suspect that they have been encouraged to believe or to feel that they have already performed their full duty and that they should leave the further prosecution of the war to others. A higher morale at home with a courageous facing of the sacrifices necessary to preserve our heritage and an adjournment of expression of maudlin sentiment will help to preserve these men and help to win the war.

MSMS

Postpartum Sterilization

A Generally Indefensible Procedure

By Edward A. Schumann, M.D.
Philadelphia, Pennsylvania



Postpartum sterilization may be defined as the surgical occlusion of the Fallopian tubes without any indication for laparotomy other than the attainment of sterilization. The operation has been rapidly extended in the last few years and is now utilized in a series of medical conditions as well as for sociological states. It is contended that the procedure is completely safe and obviates the dangers of future childbirth. This paper maintains that many medical conditions for which sterilization is performed will improve spontaneously or as a result of treatment, and that the woman may subsequently desire children. It is felt that social conditions are the function of society as well and not of the doctor alone. Reasons are given why postpartum sterilization should be restricted to a very small group of cases.

■ Postpartum sterilization may be defined as the surgical occlusion of the Fallopian tube lumen by means of an intraperitoneal operation performed shortly after parturition—usually in from 24 to 48 hours, and with no existing indication for laparotomy other than the intent to prevent future conception.

The operation had been performed for some years without attracting much attention until the paper of Adair and Brown in 1939 caught the interest of the profession and in the last four years it has grown greatly in popularity.

Curiously enough the paper of Adair and Brown was not at all an appeal for the extension of postpartum sterilization, but simply advocated the performance of the operation within 24 hours after delivery, and compared this practice favorably with the performance of Cesarean section without other indications than the opportunity to sterilize the patient.

The fifty cases reported in this paper were all instances of chronic disease in which subsequent pregnancy was deemed unwise.

In many clinics puerperal sterilizations are now being done for a variety of reasons both medical and sociological.

The medical indications are usually heart diseases of some variety; hypertensive vascular disease with or without involvement of the heart; chronic nephritis; pulmonary tuberculosis; diabetes, thyrotoxicosis, and many varieties of neurologic disease. To these are often added early senescence of the patient, pendulous abdomen and excessive dental pathology, all thought to be due to multiparity with poor social and personal hygiene.

In another group of patients, inability to use contraceptives successfully or the noncoöperation of the husband leads to a request, too often acceded to, for sterilization after the third or fourth normal pregnancy.

The major medical indications for sterilization would seem, at first glance, to be not only proper but wise preventive medicine, the operation tending to prolong the life of the woman and spare her the dangers of future childbearing but even here, a little reflection will show that radical procedures may be vastly overdone. In the matter of pulmonary tuberculosis for example, the woman who at twenty-one years of age may present marked evidences of an active infection, may be completely cured at twenty-five and eagerly desire a child. The modern treatment of tuberculosis with its rest, lung collapse and the like, very often reduces this infection to a purely temporary disease with complete restoration to normal within a comparatively short time. Every physician of experience has known women, who, sterilized after their first pregnancy, are rendered morbid and unhappy because of their inability to procreate after their return to health.

Read at the Third Annual Postgraduate Conference on War Medicine, the Seventy-eighth Annual Session of the Michigan State Medical Society, Detroit, September 22, 1943.

It is common knowledge that contraceptive devices and methods have been developed so well that their efficiency is very high when they are used intelligently and most women can now prevent conception for an indefinite period. Furthermore, should such a patient become pregnant through a failure of contraception, before she is in condition to go through with a pregnancy, early termination of the pregnancy is a simple procedure and if sterilization is then indicated, abdominal hysterotomy and tubal ligation under local anesthesia is in no wise more serious a procedure than postpartum obliteration of the tubal lumen.

It is certainly conservative to say that one-half the women concerned are able to control conception by preventive measures, and if this is true then 50 per cent of postpartum sterilizations are unnecessary.

Precisely the same holds true in cases of heart disease and in many other medical conditions in which improvement may reasonably be expected to occur as time goes on. There are a few medical lesions, however, in which the above does not hold true. Well-defined hypertensive vascular disease and established nephritis do not often permit of improvement, and here one cannot object to postpartum sterilization. This is true also of active types of permanent involvement of the nervous system and almost always so in the presence of serious mental defect. The writer's objections to postpartum sterilization do not extend to the termination of the reproductive ability of idiots or insane women.

It is true that, as has been argued, sterilization is one of the safest operations in surgery and that the risks are practically nil. This is the case, but any surgical invasion of the peritoneal cavity carries with it a definite though very small mortality and morbidity. Peritonitis of unknown origin is always a possibility and postoperative embolism, adhesion formation and other complications of abdominal surgery are constant possibilities.

The danger of the operation is not considered as an important contraindication, except that the writer decries any unnecessary surgery, no matter how safe it may be.

One may summarize, then, the medical indications for postpartum sterilization as being the existence in a woman of one or more of a small group of disease entities which experience has shown offer little or no probability of improvement no matter how they be treated. To this small group may be added the rather larger one of those patients suffering from mental deficiency or real insanity of a transmittable nature.

The great majority of medical conditions now invoked as a reason for this operation are susceptible of cure or marked amelioration as time goes on and women suffering from these more or less temporary disabilities are better treated by well planned contraceptive measures, with the resulting possibility of future child-bearing should the occasion arise, than by permanent sterilization.

It is with the sociological aspect of this matter that the writer is chiefly concerned. There is a growing tendency in a number of clinics for the obstetrician or the social worker to confer with patients who have borne a number of children, sometimes with short intervals between pregnancies as to the advisability of the definite prevention of future conceptions. The most pernicious feature of this practice is the ease with which a woman, at the end of a debilitating pregnancy or just after she has completed the effort of labor, may be persuaded to forego similar experiences henceforth. The same woman who eagerly accepts sterilization 24 hours after delivery, may bitterly repent her decision after a year has passed.

This brings up the whole question of what constitutes a proper number of children, the advantages and disadvantages of rapidly repeated pregnancies not only with regard to the health of the mother but the standards of living in which the children are reared.

There is very little factual knowledge as to the deleterious effects of frequent childbearing upon women. As to the children, statistics are also quite variable. Gruber finds that "the third and fourth child of the same woman are the strongest and that, beginning with the fifth, sometimes with the fourth, their vitality diminishes pretty rapidly. The unfavorable influence is especially great, where pregnancies follow each other within one year. Westergaard has worked out that out of 100 children who were born within one year after a brother or sister, 19.9 died before they reached their fifth year; but out of 100 who were younger by more than two years,

only 11.8 died. Even those children who were born between one and two years after their predecessors showed a fairly higher mortality than children who followed after a longer interval. Pregnancies should not, therefore, succeed one another more rapidly than at intervals of two and one-half years."

Unfortunately, these figures deal only with the mere fact that definite numbers of infants perished, under varying intervals of pregnancy. They do not state whether the deaths were due to malnutrition from improper feeding, poor hygiene or indeed, any cause. It may well be that the discrepancies may be due to social maladjustments rather than biological defects.

As against this one may call attention to the many persons of great mental and physical vigor who were the youngest of very large families. Benjamin Franklin is one of the most notable examples.

However, this communication deals with the effect of multiple childbearing on the woman, not the offspring, and here the lack of definite knowledge is always evident.

Every doctor knows the woman who is prematurely aged at forty. With teeth destroyed by caries, a pendulous abdomen and very likely a beginning procedentia, and who presents a living example of the debility attending frequent pregnancy and labor.

In strong contrast is the youthful matron of equal age, who has borne an equal number of children and who enjoys excellent health and in whom senescence has apparently been not advanced but delayed, by the events of reproduction.

This whole subject is so complex, there are so many intextricably entwined factors, of nutrition, environment, community sanitation, housing and the like, that to single out the mere fact of multiparity as the causative agent has no validity.

It might be possible to amass data in which the effect of large families to maternal health could be portrayed in relation to the social status of the mothers, the grade of medical care they received during pregnancy, labor and the puerperium, the effect of housing and nutritional variation and so on. This would be an enormous task, but would well repay the doing. The subject is an immense one presenting definite medical aspects, it is true, but it is much more closely linked to economic, social and community problems and underlying all, the rights of individuals and families to live life as they choose.

When the doctor steps into this intricate maze of complicating elements and with scalpel and ligature puts an unalterable end to a woman's reproductive life, he ignores all the other phases of sociology and says in effect, "In my opinion this woman has borne more children than may be reared by her and her husband in what, in my opinion, is a minimum standard of child life, health and education. I therefore decree, that with her consent, this woman shall never, under any circumstances, bear another child."

It may be argued with some truth, that the doctor does and should play an important part in matters of community and personal welfare and that he does in close connection with governmental agencies, supervise the premarital health of individuals, including the right to forbid marriage when either partner is found suffering from venereal disease in transmissable form.

He does originate and with the social worker, direct bureaus of marriage counsel, spacing of children, prevention of the spread of contagious disease and many like phases of sociological activity.

It will be observed that in all of the above matters the position of the medical profession is one of advice and education and not of actual interference.

Take so simple a question as that of vaccination against smallpox. Physicians have long recognized the necessity for universal vaccination and have secured in most of our States legislation rendering this safeguard compulsory among all children attending public schools, and among all citizens when an epidemic threatens. The doctor, however, has no right to insist upon vaccination of any individual unless he is so supported by the laws enacted by Society as a whole and under which laws he proceeds.

The late Gilbert Chesterton once wrote a charming essay called Topsy Turvy Land in which he deftly satirized many of the absurdities which exist in our civilization. He uses as one of his texts a newspaper debate as to whether a bank clerk on a salary of 30 shillings per week should marry. This says Chesterton, is pure evidence of upside down thinking. The real point is should

a healthy and vigorous young man be prevented from living a complete life and producing children because Society dënies him sufficient money with which to do so.

Applying the same logic to the question under discussion, the question may be posed as to whether it is not the duty of the State to see to it that a fertile married couple may produce as many future citizens and workers as they are capable of doing with the assurance that proper environment and nutrition is available to them.

The crux of this whole matter is the extent of the power of the physician in regulating family life in so far as reproduction is concerned. Where do his prerogatives and duties end and how far should he assume authority in performing acts which are irrevocable and whose consequences may be far reaching, and which intrude upon the definite duties of organized society as a whole.

It may be argued that all this is a great pother about a small matter, that postpartum sterilizations are always performed with the consent of the patient and frequently at her urgent request and that they serve to aid communities in the regulation of possibly unwise pregnancies and indeed to anticipate the social progress in which the community shows a definite lag.

A fairly parallel instance may be cited as regards the delivery of children by Cesarean Section as against the vaginal route.

In quite a few sections of the country there arose a few years ago, a tremendous vogue for abdominal hysterotomy as a method of childbirth regardless of indications. Women told each other of the ease of this system, babies to be delivered by elective section at a time convenient for mother and accoucher, and without any of the pains and anxieties of labor. It was also pointed out that abdominal delivery dispelled the dangers of birth injuries to the child and was, on the whole, somewhat safer for the infant.

Even though the patients advocated and, indeed, demanded delivery by Cesarean section, the obstetric profession opposed the practice vigorously and today in estimating the quality of work done in various clinics, the relative number of sections performed is always under close scrutiny. Institutions and obstetricians presenting too large a ratio of abdominal deliveries are continually on the defensive to explain these unnecessary operations.

This seems to be precisely the status of postpartum sterilization performed without important and definite medical indications.

There are certain pschycological sequelæ of sterilization, the effect of which upon family life has perhaps been underestimated or at least has not been freely discussed when this question is under consideration. Sometimes when a woman has been sterilized upon a merely social or a feeble medical indication, it happens that the husband either dies or divorce takes place. Presently the woman remarries and finding herself happily situated, with her new husband desires children often at his insistence. Knowledge that she is irrevocably barren may bring bitter heart searchings and a serious questioning as to the correctness of the medical advice in consequence of which the sterilization was allowed.

In other instances calamity overtakes the family. In one such case with which I am familiar, the five children of the couple were instantly killed in an automobile accident.

The mother had been sterilized shortly before upon the ground that contraceptive measures had proven unsuccessful and that the woman had borne as many children as she could properly rear.

The grief of this family when they realized that under no circumstances could another child be borne to them was profound and resulted in serious psychic deterioration of the mother.

There is another rather unpleasant aspect of the effect of sterilization of women, for whatever cause, upon conjugal relationship. Although tubal ligation has no effect whatever upon sex characteristics it is often difficult even for an intelligent layman to appreciate this fact fully and any decrease in the libido of his partner sometimes cause a suspicion which as time goes on becomes a settled conviction that the operation must be responsible in some way. The usual end result needs no further discussion.

Again, the woman herself may be a person of somewhat unstable moral fibre, possessing withal a vigorous sex consciousness. Realizing that the danger of conception is no longer a valid deterrent, extramarital relations all too often break up the family life.

Sterilization after Cesarean section, while not strictly germane to the subject under discussion, still merits consideration here. It would seem that no woman should be placed in peril of her

life more than once and although the same rules hold good as were suggested in planning sterilization upon medical indications, still in the case of the Cesarean section of the abdomen is already opened and here the patient herself, should be the judge as to whether she is to run the risk of a second section. This is particularly true since no operation is involved other than that already in progress for the delivery of the child.

The purpose of this paper is to comment upon some of the evils which may so readily follow upon postpartum sterilization. It has been shown by simple logic that a large number of such sterilizations are unnecessary even though done upon a legitimate medical indication. It has been argued that the physician is often tempted to assume a somewhat godlike pose as regards advice to women who in his opinion (and in theirs) have failed to regulate their procreative faculties with discretion and in accord with their spiritual and material opportunities to enjoy a satisfactory life.

Some of the more remote psychic maladjustments which may follow have been considered, and one has attempted to point out that the failure of society as a whole to attend to matters involving the life, security and happiness of the people comprising such society, cannot often be corrected by medical or surgical intervention alone.

To aid in the education of Society regarding social problems is the important contribution of the medical profession rather than the attempt to dispose of these problems by radical measures.

The title of the paper is harsh, the arguments involve usually only the negative side of the subject and the virtues of postpartum sterilization have been largely ignored.

This has been done deliberately in order to marshall the objections to the procedure in concise form and to invite the profession to scrutinize the whole large matter closely and objectively in order to prevent a plausible and simple attempt to solve a world-old problem from gaining too much headway and from being grossly overdone.

MSMS

Modern equipment for flying at high altitudes has been developed carefully as scientific knowledge of the effects of altitude on the body increased. Plane and flyers are adjusted to the stratosphere by intricate tests and apparatus.

Edema in Children

Causes and Treatment

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The various physiological and pathological mechanisms of edema formation are discussed briefly. The role of protein dietary deficiency and inability of the body to fabricate serum proteins are stressed. Recent advances in our knowledge concerning the etiology and treatment of nephrotic, nephritic and cardiac edema in children are likewise reviewed. Because of widespread partial starvation, the incidence of edema among children in war-torn and occupied countries is extremely great. The important relationship of this state to the general health of the child population is given special attention.

■ THE INCIDENCE of edema among children varies greatly in different parts of the world due largely to variations in the prevalence of the primary disease conditions which give rise to it. In many war-torn countries today it is the most apparent sign of serious and widespread malnutrition. If edema is defined as "retention of water in the body tissue spaces in abnormal amounts," it is obvious that this state of superhydration occurs far more frequently than is ordinarily considered to be the case when pitting of the subcutaneous tissues on pressure is the sole criterion used for its detection. An older child may, for instance, accumulate as much as five or six pounds of edema fluid before its presence is detectable by palpation or inspection, if the distribution of water is general and the elasticity of the skin and subcutaneous tissues is not too greatly reduced.

The clinical disorders with which edema is most frequently associated in early life are the following:

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1. Malnutrition
   (a.) Inadequate protein intake
   (b.) Faulty digestion and absorption of proteins (e.g. in chronic cystic pancreatitis or in prolonged drainage from high enterostomy or in chronic diarrhea)
   (c.) Possibly inadequate intake of vitamins (particularly thiamine and ascorbic acid)
2. Certain forms of liver disease
   (a.) Idiopathic atrophy
   (b.) Severe cirrhosis
   (c.) Chronic passive congestion (e.g. in constrictive pericarditis)
3. Diseases of the kidneys
   (a.) Lipoid nephrosis
   (b.) Nephritis, particularly chronic forms
4. Cardiac decompensation from
   (a.) Rheumatic carditis
   (b.) Congenital cardiac defects
5. Anemia
   (a.) Hydrops foetalis (with congenital erythroblastic anemia)
   (b.) From repeated hemorrhages
   (c.) Following extensive burns
   (d.) Miscellaneous forms
6. Allergic and toxic states
7. Certain disturbances of endocrine function

In spite of obvious dissimilarities between the primary clinical disorders represented in this list, the underlying physiological mechanisms responsible for the edema formation are essentially the same in many of them. Since the composition and the spacial localization of the body fluids, as well as the general conditions determining their exchanges, have been so thoroughly discussed in recent years by Gamble,[3] Peters,[9] and others, it is unnecessary to describe these basic concepts here. However, knowledge concerning the various forces which govern the exchanges of water between the blood vascular system and the body tissues is so important for a proper understanding of the edema problem, that brief reference must be made to this aspect of the subject.

The chief factors known to favor the development of edema are the following:

1. Imbalance between
   (a.) Hydrostatic or filtration pressure within the capillaries (relative increase) and
   (b.) Colloidal osmotic pressure of the blood plasma (relative decrease)
2. Increased colloidal osmotic pressure of interstitial fluids
3. Decreased extracapillary tissue pressure (hydrostatic)
4. Decreased tissue elasticity
5. Increased capillary permeability (e.g. from malnutrition, local anoxia, toxic or allergic injury and increased environmental temperature)
6. Increased intake or retention of sodium salts
7. Obstruction of lymphatics

While the first of these factors, which was originally described by Starling,[3] is by all odds the most important in the average case of generalized edema, some of the other abnormalities almost invariably accompany it at one stage or another. The diagnostic appraisal of such cases is incomplete and the results of therapy are often unsatisfactory, if the coexistence of these minor physiological disturbances is not taken into account.

According to our present knowledge, the fluids of the body are divisible into two general kinds, one *intracellular* and the other *extracellular* in location. The former, which comprises between 65 and 70 per cent of the total body water, is further characterized by its relatively high content of proteins, potassium, and phosphates and, under normal conditions, by its almost complete lack of sodium and chloride. Exceptions to this latter generalization are found in the case of the red blood cells, the renal epithelium and the special secretory cells of the gastrointestinal tract. These are relatively unimportant, however, from the viewpoint of the total water balance. The *extracellular fluid,* which is characterized by its relatively high content of sodium and chloride and its comparatively low content of potassium, is further divided into the intravascular and interstitial compartments. These differ from each other only slightly as regards their electrolyte and organic crystalloid composition but differ greatly in their protein content. The blood plasma normally contains between 4 and 5.5 per cent (by weight) of albumin and between 2 and 3.5 per cent of globulin in addition to from 0.2 to 0.4 per cent fibrinogen; whereas, the interstitial fluid, an ultrafiltrate of plasma, contains but a small fraction of 1 per cent of protein. Maintenance of this difference is of the greatest significance for the normal exchange of fluid between these extracellular fluid compartments. The total osmotic pressure exerted by the intravascular colloids normally amounts to between 22 and 25 mm. of mercury. The serum albumin, having a much smaller molecule than the globulins, exerts an osmotic effect between three and three and one-half times that of the latter fraction on the basis of percentage content. The hydrostatic pressure within the capillaries is normally somewhat greater than the colloidal osmotic pressure near their arterial ends.

Normally the balance between the effective hydrostatic pressure (hydrostatic pressure of

plasma minus hydrostatic pressure of tissue fluid) and the effective colloidal osmotic pressure (osmotic pressure of plasma minus osmotic pressure of interstitial fluid) is such that essentially protein-free fluid is forced from the blood stream into the tissue spaces near the arterial ends of the capillaries and from the tissue spaces back into the capillaries near their venous ends. As the blood flows through the capillaries, the plasma proteins, to which the plasma colloidal osmotic pressure is almost entirely due, gradually become more concentrated as a result of the outward flow of water and at the same time the hydrostatic pressure gradually decreases toward the venous end of the capillary bed. It is obvious that fluid is drawn back into the capillaries at a normal rate only when the colloidal osmotic pressure of the plasma exceeds the falling hydrostatic pressure. Edema occurs, when, for any reason, the hydrostatic pressure within the capillaries is increased beyond a certain level (the protein concentration remaining unchanged), or when the serum proteins are decreased below a critical point (in young children approximately 2.0 ± 0.25 per cent albumin or 5 ± 0.25 per cent total protein) without a corresponding fall in hydrostatic pressure. The critical protein level for edema formation may vary somewhat as a result of the other factors included in the foregoing list. Increased intracapillary hydrostatic pressure is observed clinically almost exclusively as a result of increased venous pressure, not being materially affected by arterial hypertension until the general arterial pressure approaches a level of 300 mm. of mercury.

Clinical Disorders in Which Edema Presents a Special Problem

Cases of edema seen in practice or in the pediatric clinic can be classified most conveniently according to the predominating physiological mechanism responsible for the water retention. The most prominent general group is that in which hypoproteinemia plays the predominant role. The second in importance is that in which the edema is due primarily to increased venous (and capillary) pressure. The third is a miscellaneous group presenting evidence of increased capillary permeability due to toxic or other injury. A fourth and more distinct group is that in which extensive obstruction of the lymphatic system accounts for the fluid retention. In addition there are many mild cases in which several of the above factors contribute to the edema formation simultaneously but without any single one consistently predominating.

Hypoproteinemic Edema—Cases of edema due primarily to a reduction of the plasma proteins and consequently to decrease in the colloidal osmotic pressure divide themselves into several subgroups according to the cause of the hypoproteinemia. These are as follows: (1) those due to a dietary deficiency in protein (starvation edema); (2) those having an adequate intake of suitable proteins but suffering from impaired digestion and absorption of these food essentials, (3) those receiving, digesting and absorbing adequate protein but suffering from impaired ability to fabricate serum proteins and (4) those who lose serum proteins from the body (by way of the kidneys, great serous cavities or through seepage or drainage from extensive burns or other lesions) at a greater rate than they can be fabricated. Obviously there may be some degree of overlapping of these clinical groups.

Nutritional Edema—Numerically the most important of these groups is by all odds the first, namely, the type due to inadequate protein intake. In some countries, such as China and India, where famine has long been common, in others where war has imposed prolonged periods of partial starvation, and in regions (such as parts of our own Southern States) where dietary habits among the poorer members of the population involve an inadequate intake of protein, nutritional edema is particularly common among the children. Their protein requirements are far in excess of those of the adult members of the population because of the special demands imposed by the growth factor. The globulin fraction of the serum protein is reduced in severe starvation edema but less strikingly than the albumin fraction. In this type of case the diminution of serum proteins represents but one of the important abnormalities present. As pointed out by Weech,[14] the total amount of hemoglobin and of body-cell proteins are likewise greatly reduced. An accompanying vitamin deficiency may also complicate the picture. This is particularly important if the thiamin intake has been inade-

quate. Cardiac insufficiency of the beriberi type is not infrequently a contributing factor.

The treatment of pure nutritional edema consists of giving the patient a diet low in sodium chloride content but high in proteins and the various vitamins. The food proteins found by Whipple and his associates,[4] to have the highest serum-protein regenerating values should be given if selection is possible. Next to blood proteins, liver, soybeans, muscle and milk proteins stand highest on the list. Intravenous plasma or whole blood transfusions and infusions of amino acids may be employed to advantage in severe cases as emergency measures.

Hypoproteinemic Edema Due to Impaired Digestion and Absorption of Proteins.—This condition occurs not infrequently in children suffering from such disorders as chronic diarrheas, chronic acinar or cystic pancreatitis (celiac syndrome) or high intestinal enterostomy. The final effect of these conditions is similar to that in starvation edema. Cases representing these subgroups are seen from time to time in all large pediatric clinics. Obviously treatment of the edema consists of building up the protein level of the serum primarily by the intravenous administration of whole blood (particularly if anemia is present), plasma or amino acid solutions while attempting to remove the underlying disability.

One of our most recent cases with severe edema illustrates the findings to be expected in patients falling into the foregoing category. The patient, an 18-months-old girl, had shown anorrhexia, vomiting and diarrhea for three and one-half months before admission. Marked edema had developed gradually during the last three weeks of this period. Albuminuria or signs of cardiac disease had been looked for repeatedly by the family physician but were never found. Nor were they ever present during the month of hospitalization before her death. Since extensive cortical atrophy of the adrenal glands was found at autospy, it was presumed that this disorder was the underlying cause of her anorrhexia, vomiting and persistent diarrhea.

Before any plasma was administered the total proteins of the serum ranged between 3.18 and 3.70 per cent, both fractions being greatly reduced (albumin varying between 1.9 and 2.3 per cent; globulins between 1.03 and 1.5). The hemoglobin was reduced to approximately two thirds of the normal value. The blood ascorbic acid value was 0.5 mg. per cent. Hypoprothrombinemia was likewise present but no tendency to hemorrhage had occured. Plasma cholesterol was reduced to 93 mg. per 100 c. When the patient was being given a mixed diet by gavage, the stools were somewhat bulky and showed fat to constitute around 40 per cent of the total dry matter (normal below 17 per cent). After 360 cc. of four-times concentrated plasma and 300 cc. of whole blood had been given in the course of several days, the edema completely disappeared. At no time did the total serum protein value rise above 4.97 per cent, however, the albumin being 3.08 per cent and the globulin fraction 1.89 per cent at the time of the diuresis. Since the total amount of plasma protein given intravenously within a few days amounted to more than three times the total quantity circulating in the blood stream of a normal child at this age, it is apparent that much of that injected must have been catabolized or utilized to replenish other stores of body protein. A larger part of that injected than is apparent from the comparatively small increase in percentage of proteins in the serum probably remained within the vascular system. There it probably served to restore a somewhat shrunken blood volume. This fraction would, however, account for a minor part only of the extra proteins given. What role the factor of cortico-adrenal insufficiency *per se* might have had in the production of edema, aside from its apparent responsibility for the occurrence of anorrhexia, vomiting and diarrhea, was not suspected until a few days before death. Specific therapy was given but was ineffective.

Hypoproteinemic Edema Due to Impaired Ability to the Liver to Fabricate Serum Proteins.—This condition has now been thoroughly established as a clinical entity. The concept involved in the characterization of this group of cases was first enunicated by Thompson, Ziegler and the author,[13] in 1932 in connection with a case study and was more completely reported by these authors and Bell,[12] in 1936. A considerable number of reports of similar nature have been published since that time.

A two-year-old girl, who had shown generalized edema of gradually increasing severity for more than a year prior to her admission to the University of

Minnesota Hospital without ever having had albuminuria, cardiac insufficiency or disease of the gastro-intestinal tract. Her diet, carefully supervised from the time of her birth by a well-trained pediatrician, had always been taken well and had always been quite adequate in protein and vitamins. The general growth and development had been essentially normal in spite of the edema.

After it was discovered upon her admission to our Pediatric Service that her serum proteins were symmetrically decreased to less than half of normal values, she was maintained on a high protein (and otherwise complete) diet for six months during which time nitrogen balance studies were carried out. In spit eof her showing a strongly positive nitrogen balance consistently throughout this period without vomiting, diarrhea, proteinuria or loss of protein by way of the asctic or pleuritic fluids, there was no evidence whatsoever of increased production of serum proteins. The hemogoblin and blood lipids were maintained at normal levels and somatic growth proceeded normally. It was then tentatively concluded that the fault lay in a specific inability on the part of the patient to manufacture serum proteins at a rate sufficiently rapid to maintain a level above that which is critical for edema formation. Disease of the liver was suspected, but jaundice or other signs of hepatic insufficiency had never been observed and the various clinical tests for impairment of liver function revealed no further evidence to support this assumption.

Plasma proteins given by vein in amounts calculated to elevate the level in her serum above that considered to be critical for the development of edema, caused a marked diuresis with complete disappearance of the edema. The serum albumin level rose from 2.09 to 3.08 per cent and that of the globulins from 0.45 to 2.82 per cent as a result of the blood transfusions. In contrast with the emaciated appearance of children who have suffered from general malnutrition as well as edema after the latter has suddenly been eradicated, this patient resembled a normal child, except for excessive wrinkling of the skin in areas where it ordinarily occurs in loose folds. Although no further transfusions were given, the patient remained free from edema for a number of weeks. The serum proteins then fell gradually and mild edema recurred. At this time she contracted scarlet fever and developed acute otitis media and mastoiditis which caused her death. Postmortem examination revealed no visceral lesions other than *widespread atrophy or necrosis of liver cells* which appeared to have been present for a long time. There was no inflammatory reaction in the liver.

Other forms of liver diseases may also reduce the capacity of this organ to produce serum proteins and so lead to the development of edema. Myers and Keefer,[8] have presented evidence that this factor, as well as loss of circulating protein by removal of ascitic fluid in large amounts, often plays an important role in the hypoproteinemia and edema commonly occurring in adult patients with severe hepatic cirrhosis.

While cirrhosis of the type seen in adult life is not common in children, when it does occur in the latter, the complication referred to should be looked for. The author saw one such case in a Chinese child at the Peiping Union Medical College, but the edema may well have been due in part to deficiency of protein in the diet. At the same institution, however, two young infants suffering from congenital syphilis with extensive involvement of the liver developed marked hypoproteinemia and edema without albuminuria in spite of what was considered to be an adequate intake of protein. When one of the patients died, autospy revealed marked destruction of the liver by the primary disease. The other patient responded well to specific antileutic therapy and blood transfusions. The edema finally disappeared entirely, not to recur after transfusions were discontinued.

That severe chronic passive congestion of the liver can result in impairment of the serum-protein-fabricating function is best exemplified by the findings of Stadler and Stinger,[10] and those of the author,[5] in cases of chronic constrictive pericarditis. In both of the cases reported the incapacity of the liver to produce serum albumin and globulin was thoroughly demonstrated. These two case studies supplemented each other most satisfactorily to complete the evidence in favor of the contention that the liver plays the primary role in the production of serum albumin and probably of globulins also. The author's case showed complete recovery of the ability to fabricate serum proteins following relief of the passive congestion of the liver by means of surgical pericardiolysis. The case of the other authors showed extensive destruction of liver tissue at autospy.

Hypoproteinemic Edema Due Primarily to Excessive Loss of Serum Proteins.—This condition is more common in the United States (except for certain areas in our southern states) than any of the foregoing types. This group includes cases of nephrosis, chronic nephritis, extensive burns and all other conditions in which there is extensive loss of proteins by way of the urine, abraded skin and serious cavities. Since *"lipoid" nephrosis* is the most interesting and challenging representative of this series of disorders, problems concerning it will be considered in more detail than is feasible for other members of the group.

The primary etiology of this disease, which occurs most frequently in children between eighteen months and six years of age, is still obscure in spite of many scientific investigations

designed to explain its pathogenesis. While most attention has been directed toward the possibility that it is essentially a disease of the kidneys due to infections of various types, the evidence for such an assumption is not entirely convincing. The predominating frequency with which the pneumococcus is recovered from the nose and throat and from peritoneal exudates, when complications such as acute peritonitis and rhinopharyngitis occur, has suggested to some observers that this organism is the causative agent. However, its frequent absence in typical cases of the nephrotic syndrome and the extremely small incidence of nephrosis among the total number of patients suffering from severe pneumococcic infections, indicates that some other determining factor must exist, even if the pneumococcus should play a prominent secondary role in many instances.

Many data now available suggest that the kidney changes and albuminuria are secondary to a more profound, though admittedly obscure, disturbance in metabolism. The characteristic hyperlipidemia suggests liver disease or hypothyroidism. It should be noted, however, that the "corrected" basal metabolic rate is usually not greatly decreased in nephrosis and that intensive therapy with the thyroid hormone does not cause reduction of the hypercholesterinemia of nephrosis as it does in typical hypothyroidism. Nor are the serum proteins elevated as a result of such therapy.

It has been suggested by several investigators that serum albumin is excreted by the kidneys in large amounts in nephrosis because its chemical constitution is abnormal, causing it to be treated like a foreign protein. This view is supported to a certain extent by electrophoretic and immunochemical studies. It has also been reported that the urinary protein of nephrotic subjects is comparatively poor in sulphur and that the albumin of both the urine and the serum of these patients contains less cystine than does normal albumin. As a patient showing such abnormality improves, the character of the serum albumin is said to return to normal.

Additional evidence in favor of the theory that nephrosis is primarily a disease of metabolism, involving hepatic dysfunction, is found in the recent discovery by Farr,[2] of hypoaminoacidemia, particularly during exacerbations or "nephrotic crises." He found the blood amino acids to be 2.5 mg. per 100 c.c. under the latter conditions as compared with normal values of 4 to 5. In such crises the patient shows increased albuminuria, fever, nausea, vomiting and increased edema. With recovery the blood amino acids are found to return to normal. It is possible that particular amino acids, such as those containing sulphur (cystine and methionine) are especially deficient. General malnutrition is undoubtedly a prominent factor in most long-standing cases.

Treatment of Nephrosis

As might be implied from what has already been said regarding the obscurity of its etiology, treatment of nephrosis is largely symptomatic, no form of specific therapy having as yet been discovered. It consists of attempts to improve the patient's nutrition, to restore lost serum proteins, to combat complicating infections and to relieve accompanying symptoms. So long as edema and albuminuria of more than mild degrees are present, the patient should be kept in bed isolated from other individuals who are suffering from acute infections of any type.

On account of the chronic anorexia and associated general malnutrition usually present, special attention should be given to the need for supplying all dietary essentials in one way or another, gavage by means of an indwelling nasal tube being resorted to temporarily if necessary. Because of the excessive loss of albumin in the urine and the resulting drain on the serum proteins and undoubtedly on some of the body proteins as well, the daily diet should contain from 3.0 to 3.5 grams of protein per kilogram of the patient's expected or normal weight. The major portion of this protein should be derived from animal rather than from vegetable sources. Theoretically, liver feeding might be regarded as being especially desirable. While it is undoubtedly wise to restrict the sodium chloride intake somewhat, severe anorexia and even more serious effects of sodium and chloride deprivation result, if the patient is given none at all. Between one and three grams of this salt per day, which probably satisfies the basal requirements of young children, should be allowed. Vitamins can easily be given in concentrated form by mouth or even parenterally. The amounts of the various vitamins required per day under

ordinary conditions by young children are as follows: vitamin A, 4000 international units; thiamine chloride, 2 milligrams; riboflavin, 2 milligrams; nicotinic acid, 10 milligrams; ascorbic acid (vitamin C), 50 milligrams and vitamin D, 400 to 800 international units. Many patients with depleted stores of vitamins as well as proteins, require still higher doses at the outset. The diet *actually taken* by the patient should be examined carefully from the viewpoint of vitamin, as well as protein, intake. Supplements should then be administered to make up any deficiencies found by comparison with this list.

In some instances amino acids can be given advantageously by stomach tube or intravenously in the form of a 10 per cent solution of casein hydrolysate during periods of exacerbation, when the blood amino acid level is low and when the patient's appetite does not permit him to take sufficient protein my mouth. Farr has reported exceptionally favorable results from this procedure in one series of cases. In our experience with attempting to satisfy the patient's excessive needs for amino acids solely by intravenous administration, the results have been somewhat discouraging. Febrile reactions and further impairment of appetite have been the most common untoward responses. However, further refinements in technique may make this a more satisfactory form of temporary therapy. No matter whether amino acids or blood proteins are given, glucose should be administered at the same time in amounts necessary to prevent utilization of the amino acids or the proteins merely to supply needed energy. According to the work of Whipple, Madden and their associates,[4] serum proteins given intravenously are metabolized and so may also furnish building material for the fabrication of new cellular proteins as well as serum proteins.

For reducing the edema a large variety of procedures have been used with varying degrees of success. No one method has been uniformly successful, even when repeated in the same patient. In addition to the measures already referred to, the following have been employed:

1. Whole blood or unmodified plasma transfusions.
2. Concentrated blood serum or plasma given intravenously.
3. Gum acacia or pectin solution (8 to 20 per cent) given intravenously.
4. Sustained pituitary antidiuresis followed by abrupt withdrawal of the antidiuretic to precipitate diuresis.
5. Use of urea or of purine and mercurial diuretics or combinations of the latter.
6. Artificial fever therapy and protein shock therapy.

Of these measures, whole blood and concentrated human serum administrations are the most logical and the safest forms of treatment. They tend to make up for serum protein losses while improving nutrition and possibly increasing resistance to infection. Reduction of edema frequently results, if the level of serum protein is thereby elevated above the critical level for edema formation. Unfortunately, much of the serum protein is frequently lost in the urine almost as rapidly as it is administered. In this event, diuresis does not occur and the edema is unaffected. In long-standing cases much of the injected serum protein is undoubtedly utilized to restore the depleted protein of the body other than the circulating proteins. Under these conditions enormous quantities of concentrated plasma or serum are likely to be required, making the cost of such treatment almost prohibitive.

Gum acacia solution may cause diuresis by raising the colloidal osmotic pressure of the blood plasma, but is not infrequently followed by serious reactions and the gum is now known to be deposited as a foreign body in the liver and elsewhere in the tissues for long periods of time. Increase in albuminuria following the injection of gum solutions has been reported. This results in a further loss of serum protein, which is obviously undesirable and contraindicates the use of this procedure, excepting as a last resort.

Having observed in our clinic a net loss of extracellular body water in non-edematous epileptic subjects with low NaCl intake when pitressin (the post-pituitary anti diuretic hormone) was withdrawn following a twenty-four-hour period of sustained pituitary antidiuresis,[6] we subjected a series of nephrotic children to the procedure.[7] In a number of those whose serum proteins were ranging but slightly below the critical level, edema was strikingly reduced during the post-pitressin period of diuresis. The mechanism of this response involves the negative balance of sodium and chloride induced by the pitressin, but this is perhaps not the only factor of importance. Although the degree of edema was temporarily increased during the period when pitressin was

being given, no other untoward symptoms were observed and the patient's appetites and general behavior improved markedly after the diuresis was completed. Patients with the nephrotic syndrome superimposed upon severe chronic nephritis of various types with marked impairment of renal function likewise showed a post-pitressin diuresis but usually only a small net loss of body water. The method is not one of first choice even in so-called pure nephrosis, but may be given a trial after the other more physiological procedures have failed.

Often, when other methods of reducing edema have been tried in vain, diuresis may be induced by administration of urea in large doses (5 to 15 grams by mouth every six hours) or by a mercurial or purine diuretic. Intramuscular injection of salargan or of a combination of such a mercurial with a purine diuretic (e.g. mercupurin) appears to be the most efficacious diuretic in this type of case. The mercurial diuretics should not be repeated too frequently, however, because of the danger of further injury to the kidneys. Fever therapy and protein shock therapy have been advocated but are too severe to be used in seriously sick cases of nephrosis. Young children in particular respond unfavorably as a rule to these latter procedures.

At times ascites and pleural effusions become so distressing to the edematous patient that paracentesis and thoracentesis are indicated. Fluid should then be removed by means of a small trocar, most rigid precautions being taken against the possibility of infecting these cavities. In the presence of complicating infections in the peritoneal cavity or elsewhere, sulfadiazine, penicillin or other specific chemotherapeutic agents should be administered according to the type of microorganism found to be responsible. Fresh blood transfusions are likewise indicated in the treatment of such complications, particularly if anemia is also present.

The mechanism of the spontaneous diuresis, which is occasionally observed in nephrotic patients shortly after the onset of a complicating acute febrile illness, is not as yet adequately understood. The well known increase in fibrinogen (and less constant increase in the serum globulins as well), which is produced as a result of an acute infection, might conceivably elevate the colloidal osmotic pressure of the plasma above the critical level for edema formation if this was previously but slightly below it.

Orthostatic Albuminuria

While far more common in childhood than in adult life, Orthostatic albuminuria ordinarily does not cause hypoproteinemia of a sufficiently severe grade to produce edema. However, one such patient, a ten-year-old boy, was referred to the author by the family physician who had treated him unsuccessfully for more than a year as a case of chronic nephritis with edema. Special tests for orthostatic albuminuria were performed because no signs of nephritis other than the albuminuria could be found. In spite of the comparatively heavy cloud of albumin found in the urine at the time of the first examination, none was present in the fourth and fifth specimens collected at hourly intervals while he lay in a recumbent posture. His serum albumin was then found to be 2.1 per cent and the globulins 2.4 per cent. A medium-sized transfusion (300 c.c.) of whole blood caused complete disappearance of the edema.

Edema in Children Due Primarily to Increased Hydrostatic Pressure

Any condition resulting in partial obstruction of the venous return of the blood, whether local or general in distribution, tends to elevate the venous pressure and consequently the intracapillary pressure to levels which may exceed the normal colloidal osmotic pressure.

Cardiac Edema.—In our part of the world congestive heart failure with edema occurs in children most commonly as a result of uncontrolled rheumatic carditis. Chronic constrictive pericarditis or Pick's disease and congenital cardiac disorders with or without superimposed bacterial endocarditis are less frequent causes. While, so far as is known, there is no tendency for congenital heart disease to occur more frequently in one part of the world than in another, rheumatic carditis has a well-defined geographical distribution, occurring only rarely in the tropics and in northern Asia, but with alarming frequency in certain parts of Europe and in the northern part of the United States and Canada.

Increase in hydrostatic pressure within the peripheral veins and the capillaries is the chief mechanism involved in the production of edema

in the average case of cardiac insufficiency. However, hypoproteinemia may also occur in the more chronic cases as a result of malnutrition, low-grade albuminuria, and long-standing passive congestion of the liver, which impairs this organ's ability to fabricate serum proteins. Obviously, *treatment* of this type of edema is directed primarily against the underlying circulatory failure and secondarily against any accompanying abnormality, such as malnutrition and anemia. Therapy for chronic rheumatic carditis with myocardial insufficiency consists of bed rest, the oxygen tent when needed, complete diet with a low sodium chloride content and the administration of digitalis, diuretics and blood according to special indications. Surgical pericardiolysis is the only satisfactory treatment for chronic constrictive pericarditis.

Other forms of edema, in which increased hydrostatic pressure within the capillaries constitutes the chief feature of the edema mechanism, which as venous obstruction from cirrhotic changes in the liver, extensive venous thrombosis, arteriovenous aneurism and pressure from pelvic or mediastinal tumors, are occasionally seen in children but are rare in comparison with the frequency of their occurrence in adult life.

Lymphedema.—This is a form of localized edema due to obstruction of the lymphatics, seen occasionally in children. It occurs most commonly in one or both of the lower extremities, although the upper extremities and the head may also be involved. Infections, trauma and pressure of enlarged glands or tumors are the most common causes of the obstruction. A congenital form which most frequently affects one lower extremity only, making it larger than the other, apparently results from some developmental anomaly of the lymphatic system. Since the serum protein escaping into the interstitial spaces finally returns to the blood by way of the lymphatic system when the latter is blocked, such protein tends to accumulate in the retained fluid. One distinguishing feature of the edema fluid in chronic lymphedema, therefore, is its excessively high protein content—this amounting to as much as 3 or 4 per cent in some instances.[1]

Conservative therapy for lymphedema consists of elevation of the afflicted extremity when possible or use of a soft supporting bandage applied from the tip of the extremity, when the patient is ambulatory. Surgical treatment is obviously indicated in some cases. Every effort should be made in any event to prevent trauma and infection of the affected tissues.

The miscellaneous group of cases, in which the development of edema does not appear to depend primarily upon increased hydrostatic pressure, upon decreased colloidal osmotic pressure within the capillaries or upon obstruction of the lymphatics, are those in which evidence of increased permeability of the capillary walls can usually be found. The most clearly defined subgroup of cases placed in this general category are those suffering from allergic disorders. Urticaria and angioneurotic edema are examples. Fulminating acute infections, burns, certain toxic states, severe anoxia, insufficiency of some of the endocrine glands (e.g., the thyroid and adrenal cortex), chronic anemia and severe malnutrition (even without critical hypoproteinemia) predispose to the development of edema. Most of these conditions appear to do so largely because they impair the restraining function of the capillary walls. Decreased tissue elasticity is a minor factor in debilitated patients. The edema of acute glomerular nephritis appears to be dependent, in part at least, upon this mechanism of disturbed capillary function, although other factors, such as acute insufficiency of the myocardium, undoubtedly play a role in its production in this disease. Treatment of the edema *per se* is of secondary importance in most of the foregoing conditions, removal of the specific underlying abnormality being the essential aim.

Summary

The various physical forces and the pathological mechanisms of edema formation are discussed briefly. The roles of chronic malnutrition (due to protein and vitamin deficiencies in the diet or to faulty digestion and absorption of proteins) and inability of the body to fabricate serum proteins are given special emphasis. It is pointed out that nutritional edema, an extremely common condition among children in war-torn countries, serves as a fairly reliable index of the extent of undernutrition in such areas. Recent advances in our knowledge concerning the pathogenesis and treatment of nephrosis, chronic constructive pericarditis and congestive heart failure in children are likewise reviewed.

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MSMS

Office Treatment of Rectal Disease

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Most rectal ailments can be successfully treated in the office. It is as much a medical problem as a surgical one. Our apparent indifference and the fear of the knife on the part of the patient have encouraged nonmedical men to play havoc in this important field. Focal infection of rectal origin presents a territory yet unexplored, and the beginning of some major pathology in this area is sadly overlooked. The use of cathartics and enemas and oils would be drastically reduced when greater attention is rendered to the anus, rectum and lower colon.

Ambulatory proctology should become an important part of the curriculum in every recognized medical school.

■ THE reason ambulant proctology has been regarded with disfavor by many medical men has been due no doubt to the imperfection of its technique and because it is chiefly advocated by many incompetents and irregulars.

Why has this condition existed? Who is to blame? Is it not true that as medical students we are only exposed to the subject of rectal diseases as incidental to the teaching of General Surgery? Later in General Practice, unless our attention is drawn to complaints about the rectum, we are unaware of the existence of this focal area. Tonsils and teeth receive our scrupulous attention as a foci of infection. But the rectum and colon, although they may be possible secret agents sabotaging the blood stream with their Lavals and Quislings boring from within, we generally ignore. And, are there not many of us who have a distaste to local treatment of the ano-rectal region? Lastly, our attitude generally is: "You have hemorrhoids? Let us cut them out."

Our apparent indifference and the fear of the knife on the part of patients, have encouraged many irregulars and incompetents to draw on sufferers from rectal diseases with the exaggerated promises of no knife, no pain, no hospitalization, and above all—a life certificate of a permanent cure.

With some effort the general practitioner is well capable to handle most of the rectal conditions himself, for they are as much a medical problem as a surgical one.

Before discussing some of the more common rectal complaints and their treatments, may I point out a few factors worthy of our attention. Throughout its entire length the rectum is covered by three coats, mucous, submucous, and muscular; but the anterior and lateral walls of its upper portion have a fourth covering—the serous or peritoneal. Its mucosa is a continuation of the mucous membrane of the sigmoid.

The submucous coat contains blood vessels, nerves, and lymphatics. Any condition that weakens the first coat, which is the mucous coat (or the supportive layer), through pressure or irritation, would naturally produce an obstruction of the circulation of the rectal veins (which lack valves) thus retarding the return of the venous blood to the liver and causing varicosities of the veins, or hemorrhoids. May we keep this in mind when the injection treatment is discussed.

Most of the nerves above the ano-rectal line belong to the sympathetic nervous system. Please note that this accounts for the absence of pain above this area although we may have extensive pathology, whereas a minor lesion is quite painful at or below this important land-mark. When a

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patient comes to you complaining of a tired feeling, gastro-intestinal disturbances, vague ulcer symptoms, unconfirmed gall-bladder pathology, sacral backaches, arthritis, painful, scanty, or even profuse menses, or urinary disturbances and you have given this patient a careful examination including x-rays and other tests, and although the patient does not complain of the rectum, look there: it may be the focal point you are looking for. From our limited experience we are convinced that focal infection of rectal origin presents a territory yet unexplored. May we add, that one diagnosis of an early adeno-carcinoma of the rectum or sigmoid will more than compensate for the time and effort which a thorough study of the ano-rectal region would involve.

Then, we have the muscular coat, the inner circular and outer longitudinal. Both are continuous with those of the sigmoid and colon. We shall touch on that point later.

Hemorrhoids and Their Office Treatment

Regarding hemorrhoids, we have three kinds: internal hemorrhoids or those occurring above the ano-rectal or muco-cutaneous line, external hemorrhoids or those found below the ano-rectal line, and mixed hemorrhoids—a combination of both. The internal type is most frequent. Due to engorgement, overdistention, trauma or erosion of the mucous covering we may have a considerable bleeding. Later on the mucosa may become tough and the bleeding become less frequent. Some internal hemorrhoids do not prolapse. Others prolapse at defacation but return spontaneously or with a little help. There is a third group of internal hemorrhoids which can be reduced only with difficulty. If not reduced they become strangulated.

A case of uncomplicated internal hemorrhoids, in our opinion, is curable with the injection treatment.

Treatment.—First, it is essential that the hemorrhoided area be exposed to view so that it may be easily accessible for treatment. We find that the Dickerson-James-Hinkle proctoscope gives us the best results.

Second, we need a hemorrhoidal needle attached to a 10 c.c. syringe; and thirdly, the solution we are going to use. A word about this item: Originally, strong solutions of phenol were utilized resulting in sloughing of the hemorrhoid. This was attended with the danger of hemorrhage. At present reputable men advocate quinine and urea and condemn phenol in oil solution. Other equally reputable physicians advocate the 5 per cent Phenol Solution in Oil. Condemn neither, try both and still others, and use the one that suits best.

The patient is placed in the left lateral position with the knees drawn upward, and is asked to hold the right buttock with his right hand. The operator is seated behind. First an external inspection, then a digital examination is made. In absence of painful conditions, the proctoscope is well lubricated and is slowly inserted into the rectum as the patient is requested to bear down. The field is carefully looked over and a point is chosen for the treatment, either because of bleeding or greater prolapse. Before you proceed keep in mind these helpful suggestions:

1. Always replace the prolapsed internal hemorrhoid.
2. Locate the ano-rectal line. Then stay away from it, for this is the painful area.
3. Expose the area to be injected as fully as possible.
4. Insert the needle beneath the loose mucosa and not into the veins.
5. If the insertion of the needle causes pain —*stop*. You are close to a danger zone.
6. If the patient complains of pain during the injection—*stop*. The tissues may be over-distended.
7. Never exert force upon the piston. The solution should flow freely with a little pressure, and must show bulging, otherwise you may be in the muscle.
8. If a snow-spot appears at the point of injection, the needle is in and not under the mucosa.
9. Inject sufficient amount of the solution until the bulging of the mucosa shows translucency or striation.
10. Keep a record of the location of the injection and of the quantity of the solution used.
11. Do not inject fibrotic tissue.
12. Do not inject external hemorrhoids.

Usually, one or two injections will stop the bleeding. Repeat the injections at intervals of a few days. The result will be: That all the

loose mucosa is tightened up and fastened down upon the rectal wall by induced adhesion. Restoring support to the rectal plexes, the veins are contracted but not obliterated. The inflammatory induration will subside by resolution, restoring the tissues to normal.

Recurrence—Relapses occasionally occur in the injection treatment as well as following operative procedure. It is no one's fault. Time, hard work, constipation, child-bearing, et cetera are factors with which we must reckon.

Anal Fissure

An anal fissure is a tear in the anal mucosa. It is described by the patient as being of a tearing, cutting or burning character. It may be associated with a throbbing pain lasting from one-half an hour to several hours after a stool. Often it occurs posteriorly. The external sphincter muscle fibres do not decussate at this point, presenting weak support.

Cause of anal fissure may be trauma, stricture, constipation, strain, et cetera.

Treatment.—Put the muscle at rest and healing will follow. The following methods have proved effective:

1. Divulsion. Under ethyl chloride gently stretch the external sphincter but do not rupture it. Stretching relieves the spasm and healing follows. We do not use instruments or mechanical dilators. When the patient is completely relaxed you introduce the right rubber gloved index finger into the anal canal with a boring motion. As the muscle gives, a second finger is introduced and the motion is repeated; then a third and a fourth finger until complete relaxation is achieved. I appreciate the controversy that exists on this point. Try it for yourself—then pass on it. It has been very successful when done on nervous people and takes very little time.

2. If incision is necessary, local anesthesia is used. The area below and around the Fissure is infiltrated with two per cent Novacaine or any other solution you desire. When relaxation of the muscle is complete, an incision is made from the extreme upper end of the fissure down through the center into the sphincter extending well out onto the skin. The incision is made shallow at the upper end but is between one-fourth to one-half inches deep at its lower extremity, depending on the thickness of the muscle.

3. A third method is the deep posterior injection of an adequate amount of oil anesthesia. There are a number on the market. We use Propalcaine. The ampule is warmed in hot water and a two-inch No. 20 needle attached to a 10 c.c. sterile syringe is used. The left forefinger is inserted into the rectum as a guide. The needle is entered subcutaneously in the midline about one inch posterior to the anus. The needle is then passed deeply into the sphincter and the oil is injected slowly on one side and then on the other, finally under the fissure itself. The amount used is from 2 to 10 c.c. depending on the spasm and the thickness of the muscle. This is followed by gentle massage to spread the solution uniformly. Novacaine may be supplemented superficially, To remove a sentinel pile, trim the edges of the fissure, excise its base or incise it, thus leaving a clean, smooth, well-drained wound. The muscle is put at rest for a week and very seldom does a patient complain of after pain if sufficient oil anesthesia is used.

External Thrombotic Hemorrhoids

An external thrombotic hemorrhoid is an ovoid or round swelling around the anus containing one or more blood clots, usually very tender and painful. Its onset is sudden. Its cause: Rupture of a vein or veins in the perianal plexes due to constipation, strain, or no apparent cause.

Treatment.—A few drops of novacaine are injected just under the skin or mucous membrane covering the tumor. Then the tissues around and below it are infiltrated. The apex is grasped with an Ellis or a tissue forceps and an elongated section is removed with a pair of curved scissors and the thrombus or thrombi enucleated. The overhanging skin edges are trimmed away; bleeding, if any, is controlled and a sterile dressing is applied.

Other Rectal Conditions

Polyps.—A polyp can be snared off through a proctoscope often without anesthesia.

Hypertrophied Papillæ.—They cause many reflex disturbances due to their specialized nerve supply. They produce indefinite symptoms of

uneasiness and spasm and are most often associated with cryptitis. They are removed under local anesthesia and the infected crypt which often causes pricky sensation when present is treated likewise.

Pruritus Ani.—Its cause or causes are many. Correct any rectal pathology present. Don't overlook a small ulcer or abrasion in the mucosa of the anal canal. Establish drainage. Check urine for sugar. Use stilbestrol, powdered calomel, zinc stearate, potassium permanganate, et cetera and when you have done all this and more, occasionally you'll meet your Waterloo. Pray.

Fistula.—A fistula is a suppurating canal, resulting from a neglected abcess. It may have an internal opening or external outlet, or both. The tract may be straight, connecting both openings, or it may assume all sorts of deviations. Often there is more than one external opening and the tracts may pass forward on each side. But no matter how many external openings we have or the type of tracts present, deep or superficial, straight or with offshoots, horseshoe or half-moon, they all lead to one source, and that is, the original source of infection. The only treatment, in our opinion, is surgery.

Careful infiltration of the tissue is carried out. A grooved probe may be used as a guide. The tract or tracts (with their lateral offshoots, if present) are laid wide open. All the dead tissue curetted and the edges trimmed out onto the skin. A styptic pack is applied. This operation is carried out to within an inch of the external sphincter. Before healing is complete, the second stage is carried out. If the internal opening is superficial to the external sphincter, the operation is completed. If the internal opening involves the muscle, it is wise to go through its fibres by stages, allowing healing before going further. Never cut through the anal ring at one sitting.

Prolapse of the Rectum

Proplapse of the rectum may be partial if tissue consists of mucous membrane only, as is usually found in children, or involves a portion of the rectal circumference when it is associated with prolapsing piles. Or the prolapse may be complete if the entire thickness of the rectal wall is extruded and presents marked redundancy of the mucous membrane over the muscle coat.

Treatment.—You all know that many major operations have been described and practiced. Their basic principle is rectal fixation. Most of them are severe and the prognosis is not very encouraging. Since every case of prolapse, whether mild or severe, is accompanied by loose and redundant mucosa, and since the levator's ani and external sphincters constitute the strongest natural support of the rectum whose fixation is desired, we present two simple methods in treating this condition.

1. The prolapse is reduced and the proctoscope is inserted. The lax redundant mucosa is then injected with five per cent P. O. as high as possible. This is followed by a series of injections under the mucosa, spaced out as evenly as possible around the circumference of the rectum. When this is accomplished, further injections in like manner are given lower down. Between 15 to 20 c.c. of the solution is used. In children very much less. A mild antiseptic pack is left in the rectum and the patient sent home. On his return a firm diffuse enduration will be felt surrounding the rectum producing its desired fixation. Further injections are repeated within a few days if any loose mucosa is discovered.

2. Another method, while the prolapse is exposed, is to inject a few minims of 4 per cent Q. U. into the muscle coat in staggered rows. After the injections are completed the patient's protrusion is restored inside the sphincter, and the replaced bowel is packed with gauze saturated with one to three parts of Monsels, S. T. 37. This serves as an antiseptic and styptic for any slight bleeding that might occur from the punctured wounds. The patient is put to bed for 48 hours without food and given sedatives. After that the pack is removed and a soft diet is advised.

Constipation

We know that it takes four hours for the ingested food to travel through the small bowel from the pylorus to the cecum, and from fourteen to twenty hours to pass from the ileocecal valve to the recto-sigmoid juncture. On this second journey the waste product of the ingested food

(Continued on Page 508)

Billions and Bureaus

In the past ten or twelve years, we have been led to believe that there are only two remedies in the little black satchel. No matter what is wrong with you, if a billion won't cure you, a bureau will.

We must, with all possible fullness and tenderness, care for the weak and unfortunate among our people; but we must also be sure that the strong shall be kept active. Let us provide for the 20 per cent of our population who are the weak, and at the same time keep the other 80 per cent strong and independent. These are the people who want the privilege of earning an honest living and paying their honest debts and who, in the time of catastrophic illness, want to be taken care of through some type of protection which they have had an opportunity to provide for themselves, at a cost, not to exceed that which they would have to pay through taxation if government, through bureaus, furnished the same.

This nation will only be strong as it is made up of men and women who want the fine things of life, the protection for themselves and their families in sickness and in health; who know that these things must be worked for and sweated for, and paid for, and are not handed to them by a philanthropic government.

That precious heritage of freedom and struggle and free enterprize which our fathers fought and died for must continue; not only for our doctors of medicine, but for all the people of this great nation.

C. P. Leyland

President, Michigan State Medical Society.

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EDITORIAL

PAYS 20 PER CENT PRORATION

■ We announced very briefly last month that Michigan Medical Service is now out of the red. That was a goal set many months ago. We can now announce that machinery is in operation to repay the proration which we surrendered during the five months of 1941 when the continuation of Michigan Medical Service was a question in many minds. The present favorable financial condition is the result of unfaltering faith in a principle, and dogged persistence in carrying it out.

That Michigan Medical Service is filling a very substantial place with our employed groups is evidenced by the fact that just recently two thousand employes of a large Detroit concern walked out because they could not get Michigan Medical Service certificates. During the time of recouping that has just successfully passed, no large groups were sold the service, upon advice of the State Insurance Commissioner. He was unconvinced that the plan could carry out its obligations, so would not sanction taking on more subscribers. This group was told that fact, but would not be convinced until contact with the Department verified the statements.

Wisconsin is interested in a Medical Service plan and is starting one in a small way. The *Milwaukee Journal* sent a staff member to Detroit to study Michigan's plan, and published two articles in the Sunday issues of April 16 and April 23, 1944. There were six columns of favorable observations with some criticism. Editorially on April 16, 1944, they said:

"Erudite as it is, the organized medical profession of America has rarely shown brilliant diagnostic ability when examining its own ills. It has rather consistently taken the stand that the traditional American system of medical economics was sacrosanct. . . . But, unfortunately, the voice of 'Organized Medicine' when it comes to social rather than technical progress, has too often been the voice of those top bracket men of the profession whose talents or society connections have rewarded them richly and still permit them time to appear on convention programs and serve on committees that speak for the profession. . . . Now organized medicine has become greatly alarmed about 'radical' proposals for 'socialized medicine,' for 'contract medicine' and 'group medicine,' in all of which are supposed to lurk ominous perils for the practitioner and the patient. . . Happily, there has been some evidence of such concern here and there, now and then. Some of it is presented in this section of the *Journal* today in the article on Michigan Medical Service. There a State Medical Association threw itself wholeheartedly behind a plan which it felt could protect every legitimate interest of the profession and would still offer patients an easier way of meeting the costs of severe illness. . . . The plan cost the medical association a good deal of money, some severe headaches and much criticism, but more than 600,000 persons depend on it today to meet most if not all of their costs for such surgical and obstetrical care as they may need. . . .*The point is that the Michigan Medical Association, along with a very few other state groups, has done more than just see hobgoblins. It has struck out and done something."* (Italics ours.)

This last sentence of the *Milwaukee Journal* editorial is the reason for the extensive quotation. If the grave present problems of the medical well being of the nation are to be wisely solved we all have to DO SOMETHING. We have for too long been fighting something. We have been opposed to some plan, but we have failed to put forth a counter plan, or come out with a real statesmanlike program to correct the faults and offer the aid and care that is being demanded by our critics.

We have suggested Michigan Medical Service as part of the solution. We believe it could be a real, substantial part of that solution, but more is needed: *We must tell our story to the world.* We must get the ear of the reading, thinking, active groups of our people and tell the story of public health, private health, sanitary advance, gains in records of mortality, morbidity—such stories as are now coming out of the medical part of the war, such stories as have been available but untold for the past few decades.

We need a book.

FIFTH WAR LOAN

■ The Fifth War Loan will begin on June 12, 1944, a very few days before this JOURNAL is issued. War bonds have become the most significant investment for all Americans. They are a

good investment, and a real help in winning the war. The popular twenty-five dollar bond has been sold so many times that there are said to be sixty-nine in issue for every dollar bill.

War bonds are the best advertised product in history, and without a cent of cost to the government. They are purchasable at more than a million places and we are confident that our members will buy them in increasing numbers. And while buying for yourself, *why not buy one also for the Michigan State Medical Society's Postgraduate Medical Education Foundation?*

The goal for the Fifth War Loan is $16,000,000. It will be necessary for us to buy to the limit, but what better cause could there be?

THE BUREAUCRATS

■ The committee of the Council which is negotiating with the Children's Bureau on the EMIC program, in carrying out the instructions of the House of Delegates at the annual meeting in September, 1943, is still at an impasse. The response from Washington is as always, NO. Several proposals have been submitted, and refused. The last information was a request from Washington for the committee to submit another proposal. There is scarcely an incentive to submit any more proposals to a bureau whose top man wrote its legal department asking it to find authority by which the Michigan plan could be rejected! Is there not some bureaucrat in Washington who would be interested in at least once finding something to do that would please the medical profession?

The Wagner-Murray-Dingell bills are quiescent. But is that a healthy sign? Are the bureaucrats allowing us to think they have retired from the fray in order to lull us into inactivity, so that they may by a sudden coup ensnare us more deeply. We cannot afford to be caught napping. We must keep the heat on this measure or it will be sprung when we least expect it, and in a way we cannot successfully protest. That was what happened in the EMIC affair.

The Bureaucrats are full of promises, at the cost of the government, which we forget is us. They must perpetuate themselves in power. A medical program for the whole nation is too juicy a proposition for them to surrender without a fight. Our patients are ready to help in most instances if we will but give them the chance. But they must be shown that this is their problem, more than ours. The plans of service for the doctors could be comfortable and satisfying to the man who is now pushed to the limit, but there are not half enough doctors in the country to service the plan as now proposed.

Something better is needed, and we think Michigan has again shown the way to what so far is the most promising solution. Private enterprise offers more opportunity than bureaucracy.

PHYSICAL MEDICINE

■ "Secretary Foster presented the recommendation of the Bay County Medical Society that the Executive Committee of The Council urge the Michigan medical schools to offer more training in Physical Medicine, as well as the recommendation to the MSMS Committee on Postgraduate Medical Education that it include lectures on Physical Medicine in the MSMS postgraduate extra-mural courses. Motion of Drs. Foster-Sladek that the Executive Committee communicate with the Deans of the two medical schools in Michigan urging them to stress the importance of Physical Medicine in their curricula and also to suggest to the State Board of Registration in Medicine that they likewise write the Deans of the medical schools on this subject; and further that the Committee on Postgraduate Medical Education be requested to include Physical Medicine in its courses for the physicians of Michigan; carried unanimously."—From minutes of the Meeting of the Executive Committee of The Council, February 24, 1944.

It is especially gratifying to the officers of the Michigan State Medical Society to note the articles appearing in the public press of April 27, 1944, announcing the gift of $1,100,000 by Mr. Bernard M. Baruch for the teaching of and research in physical medicine. An administrative Board under the Chairmanship of Ray Lyman Wilbur, M.D., Chancellor of Stanford University, has been established to inaugurate the program. Mr. Baruch's gift was animated by the belief that physical medicine has not been given the scientific treatment it deserves. His interest in the situation arises from two causes, because his father, Simon Baruch, M.D., a distinguished surgeon of the confederate army, had been a leader in the field in the College of Physicians and Surgeons, and because of Mr. Baruch's desire to do something for the sick, and especially the ill and wounded veterans.

Grants have been made to Columbia University to establish a key center of research and teaching, $400,000. Also $250,000 to New York University to establish a center for teaching and special research in preventive and manipulative structural

mechanics of physical medicine, and a like amount to the Medical College of Virginia for a teaching and research in hydrology, climatology and spa therapy. These are all for a ten-year program. Other sums are available to selected schools and for the establishment of Fellowships or Residencies.

Doctor Foster, the Bay County Medical Society, and the Michigan State Medical Society have placed an entering wedge for work along these lines in Michigan, and this announcement shows the trend. Michigan can also be proud of the fact that this program so closely follows the Battle Creek Idea which John Harvey Kellogg, M.D., used to establish a great institution, and an international reputation.

The Director of the Michigan Crippled Children's Commission reports that not 10 per cent of the doctors are collecting the fee of $1.50 provided by statute for the making out and signing of the original examination report to the Judge of Probate through which these children are hospitalized. It is necessary for the doctor to bill the Commission through the Judge of Probate.

* * *

Bills for services to patients under the afflicted and Crippled Children's Acts, should be made out in duplicate, one sent to the hospital, and a duplicate sent to the commission. This will obviate the failure of the hospital sometimes to send the doctor's bill.

OFFICE TREATMENT OF RECTAL DISEASE

(Continued from Page 504)

loses its fluid contents, and the nearer to the sigmoid the more solid the feces becomes. It rests at the sigmoid until ready to be passed out through the rectum and anus. Therefore, the trip would normally require about 24 hours. But retention is longer than that, of all or part of the waste product in the colon. Whether this retention is due to faulty digestion or mechanical obstruction, it brings about constipation or obstipation.

Let us review what could happen because of this condition:

1. The longer the fecal mass remains in the colon, the more of its toxic substances are absorbed into the blood stream, causing mental sluggishness, vertigo, dizziness, neuritis, rheumatism, etc.

2. Absorption of these toxic materials from the large bowel reaches the liver through the portal circulation and this results in biliary disturbances.

3. Abnormal presence of fecal material in the colon hinders the onward progress of gases and reverse peristalsis follows. The gas may be forced back into the stomach causing loss of appetite and a feeling of fullness or distension.

4. The liquid fecal material in colonic stasis produces inflammatory conditions of various types which often are responsible for appendicitis and colitis.

5. Constipation lowers the resistance of the individual to bacterial invasion. The success of bacterial invasion depends a great deal on the cleanliness of the colon.

Conclusion

Now these problems and many others are daily faced by the general practitioner, and he has many successful ways of meeting them. May we suggest that the rectum and colon be given greater attention. Physical examination should include not only an external or digital examination of the rectum but the proctoscope and sigmoidoscope should be as handy as a tongue depressor.

We do not intend to convey the impression that all human ills are centered in the lower bowels as is maintained by the Yogi philosophers of India, but we do believe that this field is sadly neglected and deserves greater attention. And we repeat that this subject must be a necessary adjunct in the armamentorium of the general practitioner.



This is the section where the ragweed pollen count is the highest of any section in the United States.

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For over a decade extensive research has been carried on by Barry Allergy Laboratories to determine the irritating pollens most prevalent in your state at various seasons. These pollen counts and analytic field studies have led to the assembling of the BARRY *Stock Treatment Sets,* which offer the following features: (a) diagnostic scratch-testing may usually be dispensed with; (b) ready for immediate use, requiring no diluting or mixing; (c) flexibility of dosage. It is recommended that treatment be repeated for at least two successive years.

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Three important combinations are offered to suit the particular needs of your patients:

*Bio. No. 101: Large and Small Ragweed, 50% each.

Bio. No. 102: Large and Small Ragweed, 40% each, Cocklebur 20%.



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*A.M.A. Council-Accepted

Extract of Poison Ivy-Sumac is available in 4-vial set and 15 c.c. size.

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YOU AND YOUR BUSINESS

SYNTHETIC QUININE

The war has cut off most of our supply of quinine, but has provided us with more need than ever for it. The *Journal of the American Chemical Society* for May, 1944, reports the successful synthesis of quinine by Drs. William E. Doering and Robert B. Woodward. This new material is not a substitute like atabrine or plasmochin, but is a precise duplicate and cannot be distinguished from the natural drug. If this be true, and it is well vouched for, the benefit to our returned soldiers and to those in the field will be untold.

Chemists have tried to duplicate the quinine of the cinchona tree ever since it was isolated in 1820, but without success. In 1856, William Henry Perkin tried to synthesize quinine. He used the proper number of atoms but threw them all together and got the dye Mauve, from which has sprung the organic chemical industry. Woodward and Doering used direct approach by bringing together the proper chemical groups in the proper way to produce a substance whose exact structure was known. They also produced a "mirror-image," an optical isomer, which may have great value, and is not found in nature.

MICHIGAN MEDICAL SERVICE

A recent public opinion survey indicated that 63 per cent of the American people are demanding a better way of meeting the high cost of serious illness. The doctors of Michigan are offering what seems to be a better way, and 625,000 persons are now covered by this physician-sponsored and physician-controlled plan under which the patient may buy some protection for himself against the expense of surgical and obstetric care.

As far back as 1929 the State Medical Association of Michigan began its search for some method by which the best medical service could be made available to more persons without excessive expense to the individual patient. After ten years of investigation and discussion the association sponsored enabling legistion which allowed nonprofit corporations as Michigan Medical Service to be set up with the state Insurance Commissioner supervising, but with doctors entirely in control of professional standards and fees.

No evidence was found that Michigan Medical Service has adversely affected the total income of any enrolled doctors. It may well be that some have found it a welcome solution for slow collections and others have found it paying more than the fees they had generally charged.

But it provides one answer to the demand for easing the burden of the expense of sickness. It appears to do so without interfering with present professional standards, or essentially with physician-patient relationship.—*Milwaukee Journal,* April 16, 1944.

ADDITIONAL FUNDS FOR EMIC PROGRAM

The President has transmitted to Congress two supplemental estimates for appropriations for the EMIC program.

1. He has requested an additional appropriation of $6,700,000 for expenditure during the fiscal year ending June 30, 1944. The Director of the Bureau of the Budget justifies this request as follows:

"This item provides funds in addition to $23,000,000 previously appropriated for fiscal year 1944, by Congress for grants to States for the payment of medical, hospital, and nursing expenses for maternity care and for infants of families of enlisted men in the armed forces of the fourth to seventh grades. The supplemental amount is required for allotments to States for authorizing such services during most of May and all of June: Without it the States will have to suspend authorizations."

2. He has asked for an increase of $22,800,000 in the appropriation previously requested for the fiscal year 1945. The initial request was for $20,000,000; the President now requests $42,800,000. The Director of the Bureau of the Budget justifies this increase as follows:

"The amendment increasing the estimate of appropriation is required to meet necessary additional obligations not provided for in the amendments transmitted by your [the President's] letter dated March 31, House Document 524, and the Budget for 1945.

"Estimates previously made of the requirements of this program for fiscal year 1945, were considered adequate on the basis of information then available. Succeeding events have materially altered the basic assumptions, and information recently made available to the Children's Bureau by Service Headquarters of the armed forces has caused the Bureau to revise its estimates for grants to States to take care of an increasing number of applications for care which are anticipated in 1945."

The foregoing estimates are pending in the House Committee on Appropriations (as of May 6, 1944).

THE FOOT IN THE DOOR

Someone recently asked if the EMIC Program is the foot of federalization in the door of Medicine's house. It is, judging by complementary activities in Washington, D. C. The present aim seems to be to increase veterans' hospitals and their capacity quite rapidly. It would appear that other legislation will follow from year to year to extend fuller hospital and medical services not only to veterans but to the members of their families. So 10,000,000 veterans, plus their families, will total some 30,000,000 to 40,000,000 who will be covered by some kind of socialized health service within the next two decades, according to political forecasters in the national capitol.

Congress may never pass the Wagner-Murray-Dingell Bill of 1943. But the same results—complete control

(Continued on Page 512)

BROADENING THERAPEUTIC APPLICATIONS OF *Estrogenic Hormones*

It was only a few years ago that medical writers were inclined to question the potency and therapeutic efficacy of estrogenic substances. Today, with well defined standards of activity, and with preparations of a purity and activity unheard of less than two decades ago, estrogenic hormones have a well established place in medical practice.

The broadening therapeutic application of estrogenic hormones is well documented by acceptance of the Council on Pharmacy and Chemistry of uses which, in some instances, were unheard of five years ago. At present the accepted uses include the following:

Menopausal symptoms . . . Senile vaginitis . . . Kraurosis vulvae . . . Gonorrheal vaginitis of children . . . Painful engorgement of the breasts in puerperium . . . Carcinoma of prostate . . . Functional uterine bleeding of probable endocrine origin . . . Suppression of lactation under certain conditions.



Amniotin—a solution of natural estrogens—is available in a variety of dosage forms and potencies. For certain other uses, such as in the suppression of lactation and the checking of functional uterine bleeding, the high activity of orally administered Diethylstilbestrol commends itself. Diethylstilbestrol Squibb likewise is available in a variety of dosage forms. Recent reports[1] suggest that the nausea which frequently accompanies its initial use becomes less serious as patients gain a tolerance to its administration.



[1] *Jl. Clin. Endocrinology* 3:648, Dec. 1943.

For literature write the Professional Service Dept., 745 Fifth Ave., New York 22, N. Y.

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BUY AN EXTRA WAR BOND

(Continued from Page 510)

of Medicine and its practitioners—can be achieved by a series of amendments to important appropriation bills and resulting "directives" from active bureaucrats.

After this present wartime emergency, the "foot" must be withdrawn, and the door closed.

DON'T CASH STRANGERS' CHECKS

"Strangers are not always crooks, but crooks are usually strangers."

Always refuse to cash a check for a stranger without proof of his or her identity and title to payment. The better forms of identification are: an employe identification card or plant button, car owner's registration or driver's license (be sure and write the license number and state of issue on the check itself).

A sure "stopper" for a crook is to ask for the thumbprint to be pressed under the endorsement signature. Insist that checks be endorsed in your presence; then compare the new signature on the check with the signature on the identification card. Don't accept a social security card as final identification; remember that over 50,000 worn out or lost cards are being replaced each month. Finally, when an identified soldier or sailor requests you to cash his check, ask to see his identification tag which gives his name, address, and army serial number. Write these on the check, and ask the serviceman to write on the endorsement the name of the ship or station to which he is attached.

MIGRANT WORKERS

Migratory farm laborers working in the State of Michigan this summer and autumn will be provided with medical, dental and hospital care under the program of the War Food Administration and the Midwestern Agricultural Workers Health Association. The care will be provided in the same manner as was accomplished in 1943.

Only foreign and domestic workers who have a contract with the federal government and who are transported by the War Food Administration fall in this category. The Health Services Division, headed by a medical officer assigned by the USPHS, carries out an industrial hygiene and medical program adapted to migratory workers in the farming industry. The workers included in this program have received a physical examination which included an x-ray of the chest and serological test for syphilis. Workers showing lung pathology, infectious diseases, or physical disabilities are excluded from the program. For the most part, foreign laborers will be recruited in Mexico, Jamaica and Bahama, and will belong to medically indigent groups who are transient nonresidents.

The Midwestern Agricultural Workers Health Association, a nonprofit corporation, arranges to have medical care provided the workers by local physicians on a fee-for-service basis. No restrictions regarding the choice of physicians whose services are needed by the workers is imposed. The Association has no fee schedule; it merely requests physicians, dentists and hospitals to compute their fees on the basis of rates applicable to the medically indigent group of the community.

A F OF L EXPRESSES ITSELF ON BUREAUCRATIC DOMINATION

"Do we want a great bureaucracy to dominate American life after the war, with dictators like those we now have who can set aside collective bargaining agreements without even considering the facts on which these agreements are based? Do we want to be ruled by individuals from whose decisions there is no appeal? Do we want domination by the military? This is the Fascist way, not the American way. Yet the surest way to get this very dictatorship is to fail now to set up a democratic civilian agency to direct postwar policy, with assured representation of all groups concerned.

The above quotation was not culled from the publications of the United States Chamber of Commerce, the National Manufacturers' Association or the American Medical Association."

The original will be found in *Labor's Monthly Survey,* Vol. 5, No. 2, 1944, page one, publication of the American Federation of Labor.

If that is the policy of the A. F. of L. and the A. F. of L. actually means what that statement says, it can not, even by a stretch of the imagination, be for the Wagner Bill or similar proposals. Put the government in charge of medical and health programs, big or little, and you have a bureaucracy, big or little, dominating American life in one degree or another. If domination is bad in the field of labor-employer relations, it is bad also in any other field of human relations.—*Ohio State Medical Journal,* May, 1944.

The 79th Annual Session, MSMS, will be held in Grand Rapids, Wednesday, Thursday, Friday, September 27-28-29. The 1944 Postgraduate Conference on War Medicine will feature an outstanding program with 30 eminent lecturers from all parts of the United States and Canada. The Woman's Auxiliary will meet also. For hotel reservations write: Committee on Hotels, care of Pantlind Hotel, Grand Rapids.

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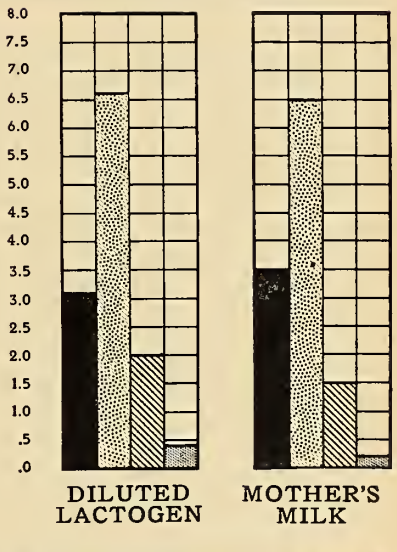
THE cows' milk used for Lactogen is scientifically modified for infant feeding. This modification is effected by the addition of milk fat and milk sugar in definite proportions. When Lactogen is properly diluted with water it results in a formula containing the food substances—fat, carbohydrates, protein, and ash—in approximately the same proportion as they exist in women's milk.

One level tablespoon of LACTOGEN dissolved in 2 ounces of water (warm, previously boiled) makes 2 ounces of LACTOGEN formula yielding 20 calories per ounce.

No advertising or feeding directions, except to physicians. For feeding directions and prescription blanks, send your professional blank to "Lactogen Dept."

"My own belief is, as already stated, that the average well baby thrives best on artifical foods in which the relations of the fat, sugar, and protein in the mixture are similar to those in human milk."

JOHN LOVETT MORSE, *A.M., M.D.*
Clinical Pediatrics, p. 156.



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IN MEMORIAM

Carroll S. Davenport, of Lansing, was born in 1898, in Dalton, Pa., and was graduated from the University of Michigan Medical School in 1922. He was resident and instructor at University Hospital from 1923 to 1925. In 1925, he came to Lansing as roentgenologist at St. Lawrence Hospital where he remained until the time of his death. An authority in his field, Doctor Davenport was a member of the Detroit Roentgen-Ray and Radiological Society, Michigan Association of Radiologist and a Diplomat of the American Board of Radiology. He died suddenly on April 26, 1944, while working at the hospital.

Stuart Lloyd DeWitt, of Grand Haven, was born January 1, 1889, in Spring Lake, and was graduated from the University of Michigan Medical School in 1911. He spent two and one-half years in Rhode Island General Hospital at Providence, R. I., serving his residency. He was well known not only in the medical profession but in the community because of his interest in the civic, education and fraternal life of Grand Haven. At the time of his death, he was a member of the board of education, chamber of commerce, and other organizations. He was a former president of the Ottawa County Medical Society. He died on March 28, 1944.

William Howard Force, of Ludington, was born in 1869, in Fowlerville, and was graduated from Wayne University College of Medicine in 1908. After graduation he located in Ludington and for nine years acted as health officer. He served as a captain in the medical corps in World War I. After spending many months following the war in postgraduate work in Chicago and at Harper Hospital, Detroit, Doctor Force returned to Ludington and entered private practice. He was active in many civic and fraternal organizations. He died on March 29, 1944.

Michael William Lash, of Detroit, was born October 13, 1913, in Detroit, and was graduated from the Wayne University School of Medicine in 1937. After graduation, Doctor Lash interned at Providence Hospital. In 1940, he completed a postgraduate course in Surgery at the University of Pennsylvania, after which he returned to Providence Hospital as the resident in Surgery. The following year he entered private practice, specializing in Surgery. Doctor Lash died April 8, 1944.

Frank Scott Tuthill, of Concord, was born in 1866, and was graduated from the University of Michigan Medical School in 1891. In July of that same year, he opened his practice in Concord. He retired in 1940 after practicing medicine for more than fifty years. Following his retirement, because of failing health, he was made president of the Farmers State Bank of Concord. Doctor Tuthill died April 18, 1944.

Robert J. Walker, of Saugatuck, was born in 1869, in Strathroy, Ontario, and was graduated from the Medical Faculty of Trinity University of Toronto in 1895. He started his medical practice in Saugatuck. Active in civic affairs, Doctor Walker served several years on the school board, was director of the Fruit Growers State Bank for thirty-five years, twelve of which, he was a member of the board of trustees. In World War I, he served as a lieutenant in the Medical Corps. He died December 11, 1943.

Arthur C. Wood, of Adrian, was born in 1872, at Lyons, Ohio, and was graduated from the Detroit College of Medicine in 1894. He began practice in Britton in 1906, and located in Adrian in 1909, where he served the community for thirty-five years. He died March 17, 1944.

John Mill Wright, of Grand Rapids, was born August 31, 1874 in Corinth and was graduated from the Detroit College of Medicine in 1895. He served on the staff of St. Mary's Hospital for many years and at the time of his death was chief of staff at Evangeline Home. He was an instructor at the old Grand Rapids Medical College for forty years. It had been his custom many years to spend three months each summer in study; he had studied in Paris, Vienna and Munich. At one time he served as secretary of the Kent County Medical Society. Doctor Wright died April 27, 1944.

Herbert V. Barbour, LL.B., of Detroit, for many years attorney for the Medico Legal Committee of the Michigan State Medical Society, died March 24, 1944. He was always interested in the problems of the doctor and ready at all times to be of aid.

MMS PAYS $127,000 PRORATION

The full amount of the sum which was withheld by Michigan Medical Service from its payments to physicians during part of 1941 will be repaid in June, according to Dr. R. L. Novy, Michigan Medical Service president.

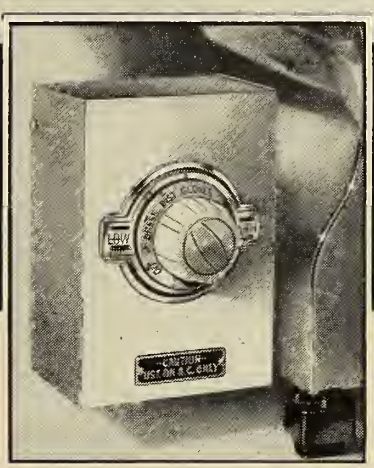
The announcement by Dr. Novy said that checks totaling about $127,000.00 will be "in the mails" before the middle of June.

This important development will clear the Medical Service books of an obligation which occurred when, for five months nearly three years ago, it was necessary to reduce payments to physicians by 20 per cent.

"This repayment signalizes a milestone in the growth of Michigan Medical Service," Dr. Novy said. "We consider it conclusive evidence that our experimental period is ended, and that we have found the remedies to our early miscalculations. Michigan Medical Service retired its deficit several months ago, and we intend to keep it 'in the black.'"

Dr. Novy also pointed out that efforts are being made to strengthen the Michigan Medical Service subscriber contract and to make possible a greater participation by physicians whose part in the Plan has been limited in the past. This matter is under consideration by the Medical Service Board of Directors and the committees, he said.

Now . . . Famous Model HP 8" x 16" AUTOCLAVE has "3-in-1" Master Control



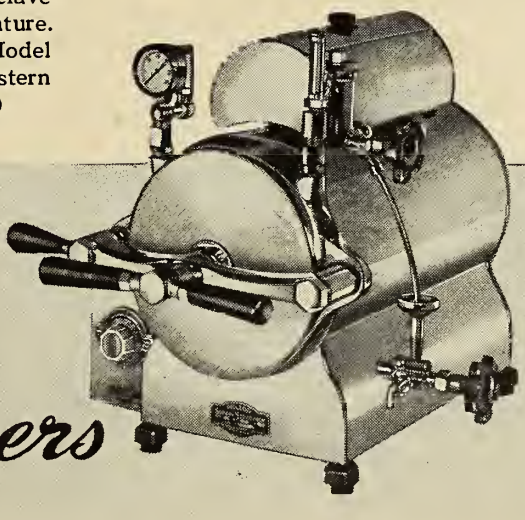
New 3-in-1 Master Control has big, easy turning knob; and pilot light.

Pelton pioneered the first automatic office Autoclave, bringing the safety of pressure sterilizing to thousands. Now Pelton has further perfected the famous Model HP Autoclave, with a fully developed control which combines on-and-off switch, pressure regulator and safety cutoff in one unit; a special variation of the device long used for automatic domestic oven control. Set it in advance to maintain any desired steam pressure, for gloves, instruments or dressings. Housed outside of the Autoclave body, away from high temperature. Now standard equipment on Model HP, listing at $245.00 (Eastern zone); $250.00 (Western zone)

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COUNTY AND PERSONAL ACTIVITIES

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Menominee—Wm. S. Jones, Secretary
Midland—Ralph R Sachs, Secretary
Muskegon—Helen S. Barnard, Secretary
Newaygo—H. R. Moore, Secretary
Oceana—W. Heard, Secretary
Ontonagon—W. F. Strong, Secretary
Sanilac—E. W. Blanchard, Secretary
St. Clair—A. L. Callery, Secretary
Tuscola—John C. Shoemaker, Secretary

As of May 10, the above county medical societies have certified 1944 dues for every member of their respective societies, to be the first 100 per cent paid-up counties for this year. A number of other societies have certified all but one or two of their 1944 members. As soon as these have paid their 1944 dues the list of 100 per cent county societies will be much larger.

Flint has a new Health Council appointed by the Mayor which is making a study of hospitalization and care of the sick in Flint. The representative of the Genesee County Medical Society on the Health Council is F. B. Miner, M.D. of Flint.

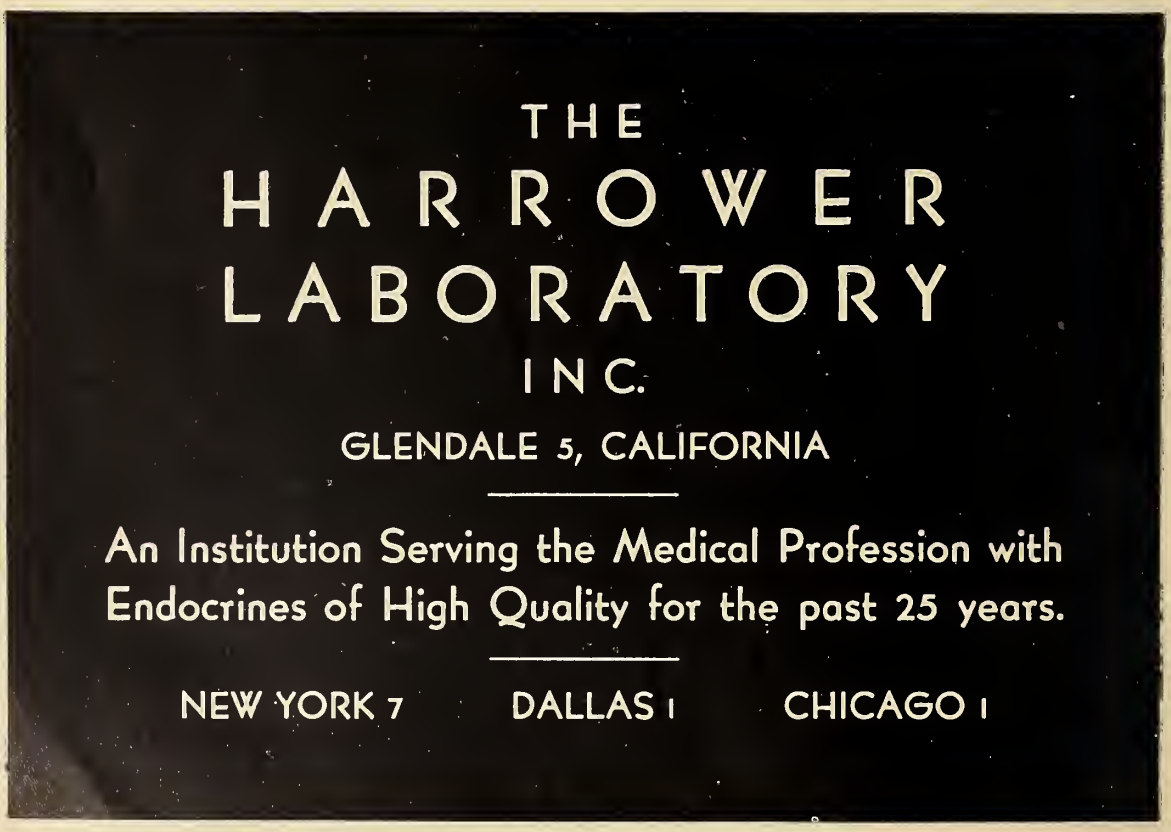
* * *

The Macomb County Medical Society has developed a leaflet, "Facts About the Wagner Bill" which it is distributing, through its members, to the public. This appeal to "you, the patient" is one of the best briefs against the proposal for Political Medicine that has yet appeared.

Congratulations, Macomb County Medical Society!

* * *

USPHS—"Rudy Lang has resigned his commission in the U. S. Public Health Service and is now in



civilian clothing. We do not know what his plans are. Rudy resigned because the USPHS has recently allowed osteopaths to have commissions in their organization. Congratulations on your courageous stand, Rudy." —Bulletin Ingham County Medical Society, March, 1944.

* * *

Medical services are not "labor" and do not represent a preferred claim in a bankruptcy case. The general ruling on professional fees, according to the Referee in Bankruptcy, Detroit, is that such claims can only be allowed as general unsecured debts for the reason that usually the physician maintains a separate place of business and must be construed to be an independent contractor. For a claim to receive the preferred allowance of a wage debt, the claimant must have occupied the position of an employe of the bankrupt.

* * *

Thirteen out of fifty-three! Michigan placed two city and eleven county health departments, out of fifty-three health departments in the nation, on the National Health Honor Roll for 1944. The Michigan health units which were granted awards are as follows: Detroit City, Jackson City, Allegan County, Barry County, Calhoun County, Dickinson County, Eaton County, Ingham County, Mason County, Menominee County, Midland County, Saginaw County, and Van Buren County.

* * *

F. A. Brockenshire, M.D., Windsor, President of the Ontario Medical Association, 1943-44, and C. S. Sanborn, M.D., Windsor, President of the Ontario College of Physicians and Surgeons, 1943-44, were honored with a testimonial banquet by the Essex County Medical Society (Windsor, Ontario), at Beach Grove Golf Club, May 3. A number of Michigan doctors attended this event, lending it an international flavor. The official representative of the Michigan State Medical Society was A. S. Brunk, M.D., President-elect. He was accompanied by Secretary L. Fernald Foster, M.D. and Executive Secretary Wm. J. Burns.

* * *

Ingham County Medical Society's May Clinic a great success. The tenth annual Clinic of the Ingham County Medical Society was held in Lansing, May 4, with 189 attending. Talks were given by John W. Hirshfield, M.D., Detroit, Mandred W. Comfort, M.D., Rochester, Minnesota, Sidney Farber, M.D., Boston, Massachusetts, Franklin B. Beck, M.D., Indianapolis, Indiana, and H. Winnett Orr, M.D., Lincoln, Nebraska. H. H. Cummings, M.D. of Ann Arbor, immediate Past-President of the Michigan State Medical Society, presided at the dinner meeting. Present from the Michigan State Medical Society were President C. R. Keyport, M.D., Grayling, L. Fernald Foster, M.D., Bay City, Secretary, Wm. A. Hyland, M.D., Grand Rapids, Treasurer, V. M. Moore, M.D., Grand Rapids, Chairman of The Council, Philip A. Riley, M.D., Jackson, Councilor of Second District, Ray S. Morrish, M.D., Flint, Councilor of Sixth District, W. E. Barstow, M.D., St. Louis, Councilor of Eighth District, and O. D. Stryker, M.D., Fremont, Councilor of Eleventh District.

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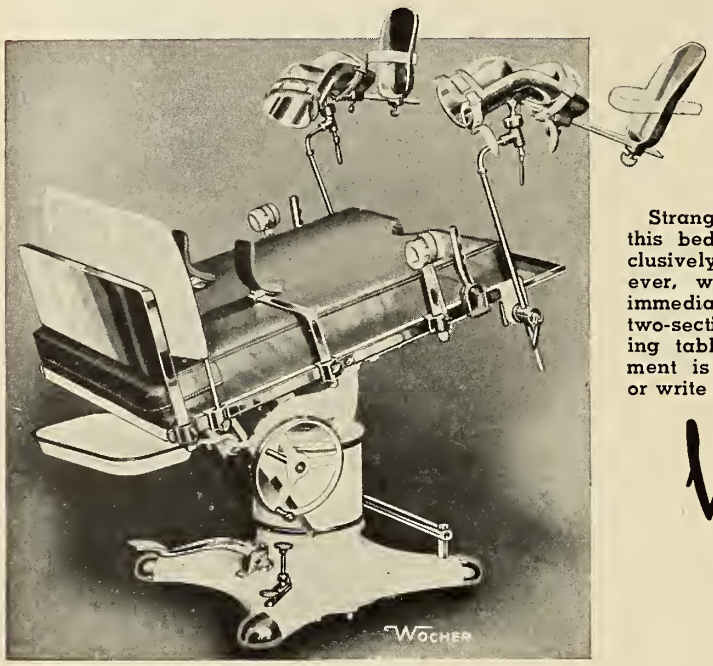
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MSMS Broadcasts.—The medical broadcasts over Radio Station WJR sponsored by the MSMS Radio Committee (Russell N. DeJong, M.D., Ann Arbor, Chairman), in coöperation with the University of Michigan, for June are presented at 11:30 p.m. every Thursday, as follows:

June 1—Paul H. Noth, M.D., Associate Professor of Medicine in the Wayne University College of Medicine: "You and Your Heart."

June 8—Henry Field, Jr., M.D., Professor of Internal Medicine in the University of Michigan Medical School: "Present Status of the Question of Vitamin Nutrition."

June 15—Leo H. Bartemeier, M.D., President of the Michigan Society of Neurology and Psychiatry: "Psychiatry and the War."

June 22—Frederick F. Yonkman, M.D., Professor of Pharmacology and Therapeutics in the Wayne University College of Medicine: "Those Drugs of Ours."

June 29—Clement A. Smith, M.D., Professor of Pediatrics in the Wayne University College of Medicine: "The Prevention and Control of Tuberculosis in Childhood."

* * *

FIVE PER CENT DECIDES ELECTIONS!

A mere four or five per cent in a constituency may determine whether a strong man or rubber stamp goes to Congress. Figure it out this way: In every district about 65 out of every 100 are registered voters. Of this sixty-five, about forty vote on Election Day. Of these forty, only sixteen vote in the primaries—which is an average of eight in either party. Of these eight, a candidate needs only five to win a primary. Thus, a minority group which knows what it wants and how to get it, may send a human rubber stamp to Congress although that minority may number less than 5 per cent of our population.—*Committee for Constitutional Government, Incorporated.*

* * *

GUEST ESSAYISTS AT 1944 POSTGRADUATE CONFERENCE ON WAR MEDICINE

At the 79th Annual Session of the Michigan State Medical Society, to be held in Grand Rapids, September 27-28-29, 1944, the following guest speakers from outside of Michigan—among others—will be on the program:

E. C. Faust, M.D., New Orleans, La.
Geza De Takats, M.D., Chicago
Robert A. Moore, M.D., St. Louis
Tom D. Spies, M.D., Cincinnati
John W. Harris, M.D., Madison, Wisc.
Arthur W. Proetz, M.D., St. Louis
Max M. Zinninger, M.D., Cincinnati
A. D. Ruedemann, M.D., Cleveland
Joseph L. Baer, M.D., Chicago
E. A. Rovenstine, M.D., New York, N. Y.
Frank H. Krusen, M.D., Rochester, Minn.
Herman Hilleboe, M.D., Bethesda, Md.
Major Frank H. Mayfield, MC, Cincinnati—now stationed at Battle Creek, Mich.
C. A. Aldrich, M.D., Rochester, Minn.
Warfield T. Longcope, M.D., Baltimore
Lt. Col. Wm. C. Menninger, MC, Washington, D. C.
Sidney Farber, M.D., Boston
S. Wm. Becker, M.D., Chicago
Brigadier Jonathan C. Meakins, M.C., Montreal
Frederick H. Falls, M.D., Chicago
James L. Wilson, M.D., New York, N. Y.
Earl D. Osborne, M.D., Buffalo, N. Y.

RECENT TALKS

Fred R. Reed, M.D., Three Rivers, Chairman of the MSMS Public Relations Committee, addressed the Calhoun County Medical Society in Battle Creek on May 2: the St. Joseph County Medical Society in Sturgis on May 9; the Jackson County Medical Society in Jackson on May 16; and the Manistee County Medical Society in Manistee on May 18.

Robert H. Baker, M.D., Pontiac, a member of the MSMS Public Relations Committee, spoke to the Holly Board of Commerce on Holly on May 4, on "Federal Bureacracy."

L. Fernald Foster, M.D., Secretary, MSMS, addressed the Bay County Woman's Auxiliary, Bay City, on May 1, and the Calhoun County Medical Society in Battle Creek on May 2. Wm. J. Burns, Lansing, Executive Secretary, MSMS, addressed the Michigan Trudeau and the Michigan Tuberculosis Association in Grand Rapids on May 25. N. J. Walton, M.D., Quincy, addressed the Quincy Rotary Club on March 6 on "Political Medicine."

* * *

Chiropractic corps in Army Medical Department. Representative Tolan of California, recently presented another gem in the nature of a bill to the Congress (H.R. 4533), to establish a chiropratic corps in the medical department of the U. S. Army. The duties of the officers will in general be to provide chiropractic service to the Army in the same manner as "other professional corps provides specialized professional service." The Army Surgeon General will be authorized to appoint officers in the corps in such number as shall be in the ratio of one officer of the chiropractic corps to each 100 officers of the Medical Department, original appointments to be Second Lieutenant. The bill also contemplates the establishment of a chiropractic reserve corps.

* * *

Osteopaths as commissioned medical officers in the Navy. Admiral Ross T. McIntire, Chief of the Bureau of Medicine and Surgery of the Navy, in discussing a bill (H.R. 4559), introduced into the Congress to permit the commissioning of osteopaths as medical officers in the Navy, stated: "It is my understanding that within the past year, some of the better schools of osteopathy have modified their curricula to include preventive medicine, and chemotherapy. This improved their courses of instruction and eventually will result in better professional qualifications for their graduates; however, at this time the standard osteopathic education does not meet the requirements of colleges of medicine which give the degree of doctor of medicine to their graduates.

"In order that all personnel of the Navy, Marine Corps, and Coast Guard assigned to the Navy, may have available to them the highest type of professional service it is considered to be to the best interests of the Medical Department of the Navy that only those physicians and surgeons who have graduated from a class A medical school be accepted for appointment in the Medical Corps.

"In my testimony of last year before this committee, I pointed out that osteopathic graduates were not given unlimited licenses to practice medicine and surgery in all

Applying Scientific Principles to a Good Idea

Scientific principles applied to the early automobile brought improvements resulting in a device that changed a way of life.

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An unusual interest, resulting in many requests for literature and samples, may cause a slight delay, but these requests will be met in the order they're received.

(1) Diseases of Infancy and Childhood, L. Emmett Holt, Jr., M.D., and Rustin McIntosh, M.D., 11th Ed., p. 905, D. Appleton-Century Co., New York, 1940.

(2) Occupational Diseases, R. T. Johnson, M.D., p. 455, W. B. Sanders Company, Philadelphia, 1941.

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States and Territories of the United States and I believe the Navy would be subject to severe criticism if it forceably subjected its service personnel to medical and surgical treatment from other than medical officers who are considered fully qualified in all aspects to administer this type of treatment. It is not practicable to accept into the Medical Corps of the Navy a group of physicians whose professional qualifications are restricted to a special type of treatment and who in many States, are not licensed to administer narcotics, and whose scope of the practice of medicine and surgery is limited."

The following quotation from "Management's Washington Letter," appearing in *Nation's Business* for April, 1944, official publication of the U. S. Chamber of Commerce, will be of interest. The Letter reads in part as follows: "Your Postwar Labor Relations program probably will include group medical insurance for workers and families—and an increased cost of doing business. Nation-wide study by Opinion Research Corp., shows only 8 per cent of population favors federal health insurance and care supported by increased Social Security pay roll deductions. But 39 per cent favor systematic prepayment of medical care on insurance principles under employer sponsorship. For whole nation, 63 per cent favor some plan 'to make it easier to pay doctor and hospital bills.' Every year 58 per cent of population see a doctor (not including dentist). But only 33 per cent are home in bed more than one day. Measured in family units, 59 per cent spend less than $50 yearly for doctors; 34 per cent spend over $50, and 7 per cent don't know total. On reasonableness of doctor bills 77 per cent of total population said not too high; while 21 per cent said 'too much.' (On hospital bills, 17 per cent said too much.) Today, 22 per cent of U. S. workers are covered by employer-supported medical plans at group-insurance rates ranging from 80c to $2 weekly payroll deductions, varying with number of dependents; and 41 per cent more say they would be interested in such a plan. Significance: approximately 80 per cent of U. S. population find prevailing medical system satisfactory and adequate; remaining 20 per cent feel family medical costs are burdensome."

* * *

The Huron County Medical Society entertained members of the Bay County Medical Society at Bad Axe on April 26. Professor Paul D. Bagwell, head of the Department of Speech of Michigan State College was speaker of the evening on the subject "Political Medicine."

* * *

Citizens, Attention! Physicians, as citizens, must become interested in the primaries of July 11, 1944, especially in candidates for the Michigan Legislature and particularly those who aspire to the State Senate. Doctors should carefully scrutinize the lists of candidates and take appropriate action. As citizens, it is your duty to help insure the nomination and election of the best possible talent for the State Legislature which body has the power to make and change the laws affecting public health and the practice of medicine.

* * *

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and willing to leave town, I can offer you a minimum guarantee of $75.00 per week refracting patients who are recommended to you. Experience in refraction is not necessary. Office space is provided. This will be a permanent arrangement with an opportunity to earn more than $75.00 per week, and requires absolutely no selling on your part. If interested, kindly wire (charges collect) at once."

This "come on" postal card has been circulated among Michigan physicians periodically for several years. It indicates the manpower-turnover problem of an advertising optical house with headquarters in Chicago and branches in various cities of Michigan. Only the waste paper drive will be aided by this literature, so consign the postal card to the nearest trash basket.

* * *

Electrocardiography.—A full-time two weeks' intensive course is offered at Michael Reese Hospital, 29th and Ellis Avenue, Chicago 16, during the period beginning August 21. Fee for course and materials is $110.

* * *

The Michigan Society of Neurology and Psychiatry.—The fifth regular meeting of the current year of the Michigan Society of Neurology and Psychiatry was held in Detroit on April 27, under the presidency of Dr. Henry A. Luce, of Detroit. The program was as follows: Mr. Lee White, Director of Public Relations, *The Detroit News,* "What the Press Thinks of Psychiatrists"; Mr. William E. Dowling, Prosecuting Attorney of Wayne County, "What Psychiatrists Can Do to Aid Justice"; Hon. Joseph A. Gillis, Judge of Recorder's Court, Detroit, "Psychiatrists at the Bar of Justice"; The Rev. Hugh P. O'Neill, S.J., Faculty of the University of Detroit, "The Clergy Looks at Psychiatry."

Leo H. Bartemeier, M.D., of Detroit, was installed as president of the Society for the coming year, and Roy A. Morter, M.D., Director of the Kalamazoo State Hospital, Kalamazoo, Michigan, was named president-elect.

* * *

Executive Orders constitute another phase of the broad control of government exercised by the President in an unprecendented manner. President Roosevelt has issued 45 per cent of all executive orders *since and including the administration of President Lincoln.* He has issued twice as many as any other President in the history of our Republic and twice as many as the combined number of executive orders issued during both the Civil War and World War I. In some years his executive orders, which often have the effect of law, have even exceeded the number of laws passed by Congress in the same period. Since he took office in 1933, President Roosevelt has issued 3,707 executive orders as compared to the 4,553 laws enacted by Congress during the same period. These executive orders are in addition to the multitude of "administrative" orders issued by his bureau chiefs in the jig-saw puzzle of New Deal agencies.—*Fred L. Crawford, MC, 8th District, Michigan.*

* * *

Governor Kelly stated that the farm manpower situation will be eased this year by the importation of 15,000 to 16,000 workers of Mexican descent, several hun-

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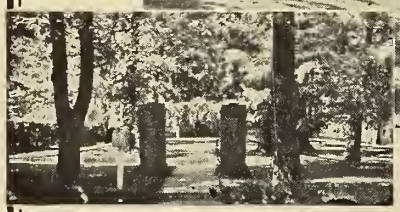
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dred Jamaican laborers, and the use of prisoners of war. A first group of prisoners of war arrived this week at Hartford. They will receive 81 cents per day for their work, but employers will pay the Federal Government the current rate for labor. The difference will contribute to their maintenance.

* * *

The Tax Study Committee listened with favor to a suggestion for a constitutional change to produce a simple, fair and workable intangible tax law. Chairman Brake, State Treasurer, said no objections were voiced to a proposal to submit a constitutional amendment to clarify "uniform taxation." Senator George P. McCallum reported against any new attempt to enact a State income tax, pointing out that voters have rejected this levy four times.

* * *

Graduate program in venereal disease in Upper Peninsula.—This special program was held the week of May 23 in the cities of Sault Ste. Marie, Marquette, Houghton, Ironwood, and Powers, and marked the culmination of a program recommended by the MSMS Venereal Disease Control Committee last year. The course consisted of lectures by L. W. Shaffer, M.D., Detroit and N. W. Guthrie, M.D., Lansing, preceded by a consultation service for physicians.

* * *

The Michigan Pathological Society held its regular bi-monthly meeting on April 15, 1944, at St. Joseph's Mercy Hospital, Detroit. The scientific session was devoted to a seminar on "Tumors of the Ovary" and was conducted by Dr. Walter Schiller of Chicago. There were 57 members and guests present.

An agreement was adopted with Michigan Medical Service and Michigan Hospital Service which provides that pathological services to subscribers for prepaid hospitalization or medical care be furnished under a contract written by Michigan Medical Service.

* * *

The Ionia-Montcalm Medical Society recently issued a Bulletin dedicated to "Our Members in the Service." This eight-page booklet, prepared by M. A. Hoffs, M.D., of Lake Odessa, is a chatty résumé of what's going on in Ionia-Montcalm Counties, just where the various military members are located and what they are doing, and many personal items which make the *Bulletin* the equivalent of a friendly and personalized letter to each physician in service who received it.

* * *

Thirty million of the Nation's 50,000,000 income taxpayers will enjoy simplified methods of making their return as a result of approval given by the House Ways and Means Committee to legislation designed to make it easier to compute and file the tax forms. Under the proposed system, the present method of withholding taxes from wages and salaries will be revised to deduct the full tax liability for persons earning up to $5,000.

The plan, which would not become effective until January 1, 1945, would abolish the Victory tax, establish a new normal rate of 3 per cent on all persons making more than $555 a year; and start exemptions from a base of $500, plus 10 per cent of income, with similar adjustments for the surtax. Surtax rates would begin at 20 per cent instead of the present 13 per cent.

The United States Children's Bureau announces the appointment of the following new members of the Chil-

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dren's Bureau Advisory Committee on Maternal and Child Health Services. These members were appointed in response to the resolution adopted by the Advisory Committee on Oct. 21, 1943, requesting that the committee be enlarged by the appointment of at least five physicians actively engaged in the private practice of medicine: Sterling H. Ashmun, M.D., Dayton, Ohio; Harvey F. Garrison, M.D., Jackson, Miss.; Eleanor Harvey, M.D., Newport News, Va.; John Preston, M.D., Tryon, N. C.; S. A. Thompson, M.D., Camden, Ark.; George D. Cannon, M.D., New York.

In addition, the following members of the Children's Bureau Commission on Children in Wartime, have been appointed ex officio on the Advisory Committee on Maternal and Child Health Services: Frederick H. Allen, M.D., Philadelphia; Leona Baumgarten, M.D., New York; Reginald M. Atwater, M.D., New York; Franklin P. Gengenbach, M.D., Denver; Joseph S. Wall, M.D., Washington, D. C.

* * *

WORKING IN SILENCE

"No headlines herald the progress of the medical profession in its efforts to distribute adequate medical care to every section of the country. As usual it serves in silence.

"The *American Medical Journal* points out that there are two objectives which the doctors seek: First, the best distribution of available resources of medical personnel and the health protection of the largest number of people; second, the doing of this in such a way as to preserve the rights and advantages that inhere in local self-government.

"Moves are afoot to ease medical licensing restrictions between states. This has been a stumbling block in the way of physicians moving from state to state in accordance with the needs of areas critically short of doctors. Another important step was the recent formulation of plans whereby the United States Public Health Service could help meet the need for medical services in critical areas. The doctors are striving, irrespective of thinning ranks, to maintain one physiciaan to 1,500 people. In some cases the average may be less, but even so, Americans will still be the best cared for people in the world.

"In Germany, doctors are practically nonexistent for civilians. Russia is no better. This fact should be noted carefully. Both the Russian and German medical systems were prepared for war, under "planned" dictatorial economics, yet the test of global war found them both wanting as compared to the progressive American medical system, built on the foundation of initiative, service and sacrifice of our independent medical profession."—Editorial in *Sandusky Republican-Tribune* (Michigan), April 21, 1944.

Selection of nursing as your vocation is a serious responsibility. Remember the parable of the talents. You have those qualities we feel are important for nursing: youth, health, personality, preparation and intellect. Make use of these gifts together with what our hospital has to offer you. But remember also to "Give and it shall be given unto you."—Augusta Dutton, *Harper Hospital Bulletin,* April, 1944.

GROWTH...
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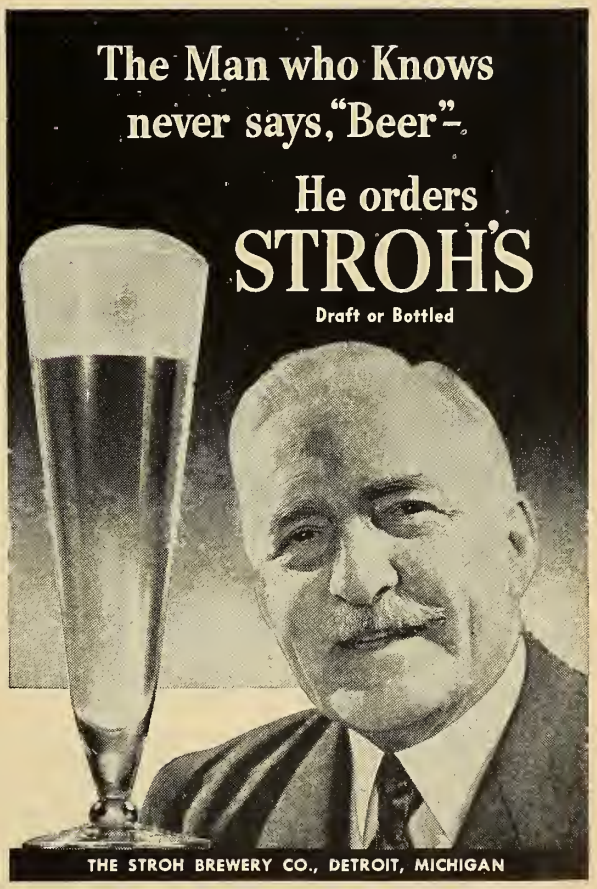
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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

ESSENTIALS OF DERMATOLOGY. By Norman Tobias, M.D., Senior Instructor in Dermatology, St. Louis University; Assistant Dermatologist Firmin Desloge and St. Mary's Hospitals; Fellow American Academy of Dermatology and Syphilology; Diplomate American Board of Dermatology and Syphilology. Second Edition. Philadelphia: J. R. Lippincott Company, 1944. Price, $4.75.

This volume is an attempt to place a handy manual of dermatology in the hands of the busy practitioner and the student, so in the haste of the times it will not be necessary to study the larger complete texts. The descriptions are concise and without long histological comments. For practical use the volume is ideal, leaving intensive study to the specialist with his tomes and treatises. This volume contains many well executed photographs, and sufficient discussion of the diseases described so that a diagnosis can be made, and the treatment is fully outlined. Inside the front cover are two pages on the use of the sulphonamides in dermatology. Inside the back cover is a long list of normal values.

A TEXTBOOK OF PATHOLOGY. Edited by E. T. Bell, M.D., Professor of Pathology in the University of Minnesota, Minneapolis, Minn. Fifth Edition, Enlarged and Thoroughly Revised. Illustrated with 448 engravings and four colored plates. Philadelphia: Lea & Febiger, 1944. Price, $9.50.

Bell's Pathology makes its fifth appearance at a time when shock, explosion injuries and vitamin deficiencies are foremost in our minds. These subjects are especially well handled in this volume, which follows the high standard of its predecessors. The text material is condensed to small space and for easy assimilation. This is a textbook of pathology that leads gradually and logically into the practice of medicine. It is a well-adapted text for the busy practitioner as well as the student.

CLINICAL LECTURES ON GALL BLADDER. By Samuel Weiss, M.D., F.A.C.S., 496 pages. Chicago: The Year Book Publishers, Inc., 1944. Price, $8.50.

This is a new book which should find immediate acceptance and enthusiastic approval by medical students in particular and the general profession at large. It fills a gap between the brief outlines designed as guides to further reading and the more massive volumes on this subject which are too time consuming for careful study.

Well written and adequately illustrated, this book provides easy and interesting reading of a complicated and comprehensive subject. The internist and surgeon alike will benefit from cover to cover reading of this important phase of their practice. The anatomy and physiology of the biliary system is well presented and emphasis is placed on the history and examination which lead to exact diagnosis.

Acute and chronic cholecystitis, pseudocholecystitis, cholelithiasis and their complications are dealt with in proper detail. The interesting question of medical or surgical management of each disease is presented and the indications for surgery outlined. Gall-bladder disease

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is discussed in its relation to arthritis, cardiac disease and other systemic infections acute and chronic. Benign and malignant tumors are reviewed. The etiology and clinical manifestations of jaundice, liver function tests, hypoprothrombinemia, and preoperative and postoperative medical care are presented in the light of recent research and clinical work, stressing new therapeutic measures.

This is not simply a reference textbook, but rather a very practical volume to study over and over again.

SYNOPSIS OF MATERIA MEDICA, TOXICOLOGY, AND PHARMACOLOGY, For Students and Practitioners of Medicine. By Forrest Ramon Davison, B.S., M.Sc., Ph.D., M.B. Formerly Assistant Professor of Pharmacology in the School of Medicine, University of Arkansas, Medical Department. The Upjohn Co., Kalamazoo. Third Edition. St Louis: The C. V. Mosby Company, 1944.

This is a condensed materia medica with practically every drug described in its proper classification, giving the effects, action, and prescriptions for the use. It includes a chapter on the sulfonamides, giving their structural formulæ, and uses. The vitamins and biologicals are included, with their structural formulæ if worked out, and administration. A very handy book.

QUARTERLY REVIEW OF SURGERY. Vol. 1, No. 2, February, 1944. By Henry N. Harkins, M.D., Editor-in-Chief. Washington, D. C.: Quarterly Review of Surgery, 1944.

This volume contains short and clear reviews of articles that have been recently published on surgery of the Thorax, Abdomen, Kidney, Blood Vessels and Lymphatics, Bones and Joints, Thyroid, Traumatic and Industrial Surgery, and general—in all, about ninety-six reviews by twenty-one reviewers. On the editorial board are the following from Michigan: Alexander W. Blain, Frederick A. Coller, Roy D. McClure. The Editor was recently at Henry Ford Hospital, Detroit.

RORSCHACH'S TEST. I. Basic Process. By Samuel J. Beck, Ph.D., Head of Psychology Laboratory, Department of Neuropsychiatry, Michael Reese Hospital, Chicago. Associate Professor of Psychology, Northwestern University. Foreword by William L. Valentine, Ph.D., Head of Department of Psychology, Northwestern University. New York: Grune & Stratton, 1944. Price, $3.50.

This is Doctor Beck's second volume about the Rorschach test, and is written to demonstrate the processes used to evaluate the test responses. This gives a manual of usage so that the reults of tests by different investigators can be compared. There is some difference of opinion as to the value of the method. These are discussed briefly, and innumerable responses are recorded. The text is interesting to the initiated, but unintelligible to the average practitioner. Its value to the worker in psychology and psychiatry could be far reaching.

MANUAL OF THE DISEASES OF THE EYE. For Students and General Practitioners. By Charles H. May, M.D., Consulting Ophthalmologist to Bellevue, Mt. Sinai and French Hospitals, etc. Eighteenth Edition, revised with the assistance of Charles A. Perera, M.D., Associate in Ophthalmology, College of Physicians and Surgeons, Medical Department of Columbia University. With 387 Illustrations. Baltimore: William Wood and Company, 1943. Price, $4.00.

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instructive. This volume is of especial value in view of the many state compensation laws fixing the value of loss of industrial vision, and methods of determining compensation. These facts are difficult to refer to on the spur of the moment or when a court case impends, but in this volume is the abstract of the AMA committee report. This one feature is well worth the cost of the book.

A NEW TEST FOR SYPHILIS. By Anson Lee Brown, A.B., M.D., Dr. Brown's Clinical Laboratory, Columbus, Ohio.

CLINICS. Vol. 2, No. 5, February, 1944. Philadelphia: J. B. Lippincott Company.

A Symposium on War Medicine is included in this issue, the teaching panels presented at the 51st Annual Meeting of the Association of Military Surgeons of the United States, Philadelphia, October, 1943. These articles are well worth reading.

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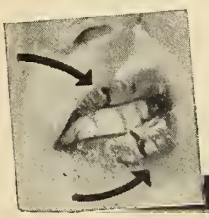
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Baker Laboratories, The 467
Barlow-Maney Laboratories 480
Barry Allergy Laboratories, Inc. 509
Borden Co. 457
Burroughs Wellcome & Co. 451, 477

Camel Cigarettes 469
Camp, S. H., & Co. 453
Canada Dry Ginger Ale 517
Central Laboratories (Detroit) 528
Central Laboratory (Saginaw) 527
Cheplin Biological Laboratories 466
Ciba Pharmaceutical Products, Inc. 465
Insert facing page 456
Classified Advertising 527
Clinical Laboratories 526
Coca-Cola Co. 520
Commercial Solvents Corporation 454, 455
Cook County Graduate School of Medicine 527

DeNike Sanitarium 525

Ferguson-Droste-Ferguson Sanitarium 521

Glidden, Otis E., & Co., Inc. 459

Hack Shoe Co. 481
Harper, I. W. 464
Harrower Laboratory, Inc. 516
Holland-Rantos Co. 472
Hotel Olds 526

Ingram, G. A., Co. 519

Kurt Co., The 463

Lederle Laboratories, Inc. 479
Lilly, Eli, & Co. 482

M. & R. Dietetic Laboratories, Inc. 468
Mead Johnson & Co. ..... Back Cover
Medical Protective Co. 525
Medical Supply Corporation 523
Milwaukee Sanitarium ..... Back Cover

Nestles, Inc. 513

Parke, Davis & Co. 461
Pelton & Crane Company 515
Petrogalar Laboratories ..... Inside Front Cover
Philip Morris & Co. 476
Physicians Casualty Association 524
Plessner, Paul, Co. 473

Randolph Surgical Supply Co. 470
Rupp & Bowman Co. 524

Schering Corporation 471
Schmid, Julius, Inc. 478
Searle, G. D., & Co. 475
Squibb, E. R., & Sons 511
Stearns, Frederick, & Co. 449
Stokes Sanitarium 527
Stroh's 523

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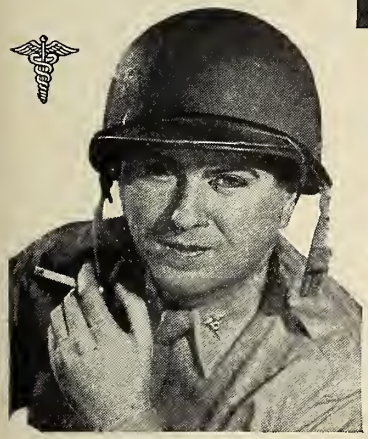
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POLITICAL MEDICINE

RESOLUTION COMMITTEE MEETS

A Resolutions Committee consisting of members and representatives of the state medical societies of Colorado, Idaho, Indiana, Nebraska, Oregon, South Dakota, Washington, Wisconsin, and Wyoming met in Denver, Colorado, April 28 and 29, 1944. The results of their deliberations are produced herewith:

The enactment by Congress of legislation providing funds to pay the cost of securing adequate maternity and pediatric attentions for the wives and children of enlisted men of the lowest four grades is an extension, as a wartime measure, of principles with which we, as practicing physicians, are in entire accord. It is our earnest desire to aid in every possible way the application of these services with fairness to the hospitals and to physicians who furnish the actual care, to the Congress of the people of the United States, which provides the necessary funds, and especially to the wives and children who need and are entitled to receive these benefits.

We, therefore, members and representatives of the State Medical Societies of Colorado, Idaho, Indiana, Nebraska, Oregon, South Dakota, Washington, Wisconsin, and Wyoming, in session in Denver, Colorado, Friday and Saturday, April 28 and 29, 1944, present for consideration the following resolutions as the expression of our deliberations:

Resolved, That further conferences may be called by the permanent chairman at his discretion for the purpose of discussion and solution of various obstetric and pediatric problems which arise under this Act of Congress.

Resolved, That the various interested state medical societies appoint a representative who can be called in to similar conferences in the future.

We, the members and representatives of the state medical societies of Colorado, Idaho, Indiana, Nebraska, Oregon, South Dakota, Washington, Wisconsin, and Wyoming, therefore present to our respective societies the following resolutions for consideration:

Whereas, a growing feeling exists throughout the country that the present E.M.I.C. program is unsatisfactory because of the autocratic and dictatorial manner in which the Children's Bureau had administered the program, thus destroying the confidence which physicians should have in the Bureau; and

Whereas, The Bureau has inflicted its own plans on the State Boards of Health and the practicing physicians and hospitals, completely ignored the advice and plans offered by the State Committees, and have thereby enormously increased the administrative cost to each state and disrupted the usual functions of the State agencies, and furthermore it has placed the soldiers' wives in the same category with indigent patients; and

Whereas, Ample and efficient facilities for the disbursement of such funds as Congress may allocate already exist in the Army Office of Dependency Benefits in Newark, New Jersey, and Bureau of Navy Personnel, Navy Department, Washington; and

Whereas, we believe that the program can be more economically, efficiently, and satisfactorily administered by direct allotments through these agencies.

We, therefore, suggest that upon receipt of an affidavit signed by any licensed physician of the state in which he resides, certifying an enlisted man's wife is pregnant, that these same agencies shall, upon termination of the case, forward to the wife such funds as Congress shall deem necessary to cover hospital, medical, and nursing care.

We further suggest that the same procedure be followed in furnishing care to the infants of enlisted men of the grades specified during the first year of life.

Resolved, that inasmuch as the principle of allotment payments has been approved by many state medical societies and the American Medical Association that Congress be urged to take such steps as may be necessary to remove this program from the direct supervision of the Children's Bureau and place it on an allotment basis, thus releasing the State Boards of Health to carry on their regular public health work and removing a regulatory board now placed between the patient and the doctor.

Resolved, That each state take definite action in conjunction with all other states in accord with these resolutions, to acquaint the congressional representatives of these states with the full intent of these resolutions; and be it further

Resolved, That copies of these resolutions be sent:

(1) To the secretaries of the state medical societies of the United States.

(2) To the American Medical Association (Olin West).

(3) To the physician members of Congress.

(Upon motion duly made, seconded and carried the above resolution was adopted.)

BRITAIN'S NEW HEALTH PLAN

London, May 13, 1944—Britain may be on the brink of one of the most revolutionary social reforms in her history, the institution of a national health service. The plan has been presented to Parliament in a White Paper by the Ministry of Health, which attempts to combine the most progressive principles of state medicine with the best elements of the present regime. It has three main objectives:

"1. Free treatment for every need, from minor ailments to major operations.

"2. To provide a network of the most up-to-date medical services and equipment, in which hospitals, the family doctor, dentists, nurses, and opticians would be included; the country would be split into areas, each of which, having a nucleus of all these services, would be medically self-sufficient.

"3. To encourage a new approach to health, which would hold that those who were averagely healthy

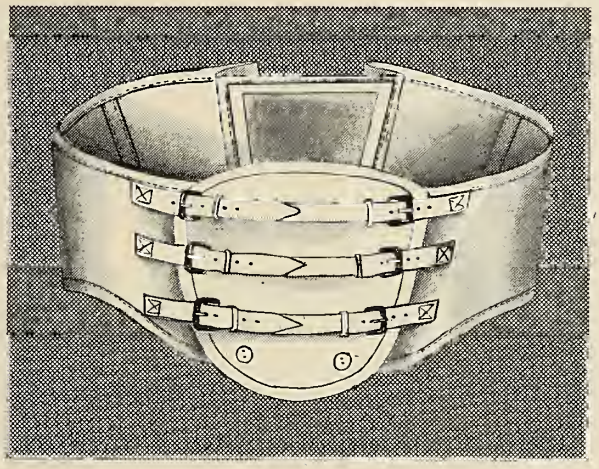
(Continued on Page 536)

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BRITAIN'S NEW HEALTH PLAN

(Continued from Page 534)

should be helped to make themselves even healthier, and that at least as much attention should be paid to the prevention of disease as to its cure."

There would be no compulsion for patient or doctor. But:

"The new service will be there for everyone who wants it—and would indeed be so designed that it would be looked upon as the normal method by which people get all the advice and help which they want—but if anyone prefers not to use it, or likes to make private arrangements outside the service, he will be at liberty to do so."

That is, if under this plan there are any left who can carry on under the handicap. And the bureaucrats in Britain are also shrewd: "The Family Doctor . . . might, indeed, be better off for he would be paid regularly by the state . . . He would also have a less exhausting life, for the proposed health center system insures that the doctor who works hard all day does not have to cope with emergency calls at night." *This White Paper seems to be a very definite straw in the wind.*

TOO MUCH SICKNESS INSURANCE, NOT ENOUGH HEALTH INSURANCE

The terms "sickness insurance" and "health insurance" connote two quite different things. Sickness insurance concerns itself with facilitating the recovery of people from sickness, once it has overtaken them. Health insurance concerns itself with minimizing the hazards that are likely to make them sick. On the theory that the more effective health insurance is made, the less will be the costs for sickness insurance, it would seem only logical that Canada should be planning to spend more and more on preventive measures that will be permanent in their beneficial effect, so that she may look forward to having to spend less and less on medical services that merely put a temporary stop to troubles that need not have happened.—From *Health Insurance for Canada* by Research Bureau, Canadian Pharmaceutical Manufacturers' Association.

NEW TAXES

Business overhead increased appreciably when new federal excise taxes became effective.

Long-distance phone tax hiked from 20 to 25 per cent; telegraph tax upped from 15 to 25 per cent; local phone tax up from 10 to 15 per cent; railroad tickets, from 10 to 15 per cent.

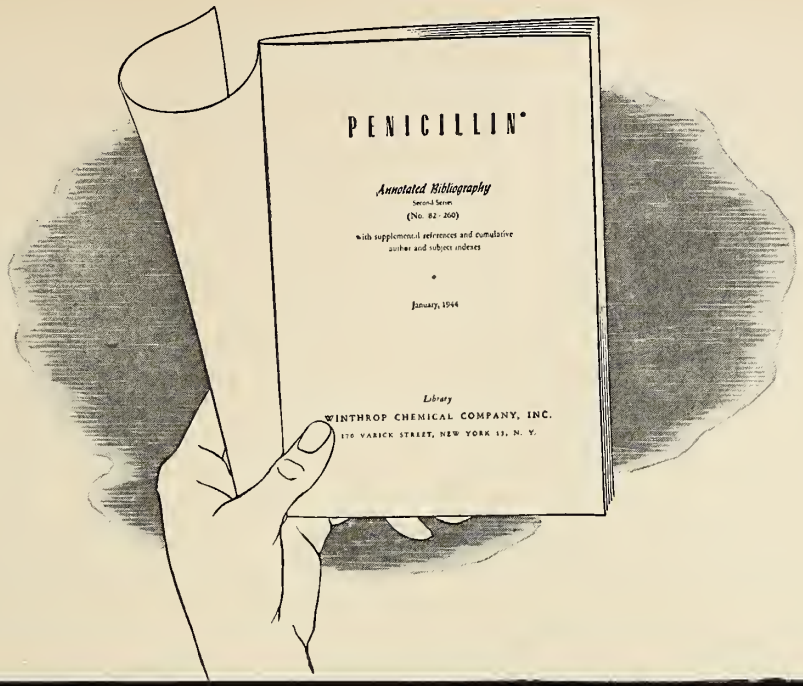
Admission tax doubled.

Local postage increased from 2 cents to 3 cents per ounce; air mail from 6 cents to 8 cents per ounce; mail insurance and C.O.D. fees doubled; registered mail fees upped one-third.

Retail toilet preparations and luggage doubled from 10 to 20 per cent.

Club dues tax advanced from 11 to 20 per cent; electric light bulbs, 5 to 20 per cent.

Social Security taxes continued at 1 per cent each for employe and employer through 1944.



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VETERANS' REHABILITATION

The rehabilitation of veterans is a specific responsibility of the Army, Navy and Veterans Administration, so assigned by law. Briefly, intensive treatment in military hospitals determines whether disabilities are recoverable and, hence, suitable to eventual return to duty. Serious handicaps receive special attention in designated hospitals where social adjustment and training go hand in hand with medical care. These patients when sufficiently recovered are discharged from the Army or Navy. Then the Veterans Administration provides vocational training and employment, provided the disability is service connected, that the person is honorably discharged and that rehabilitation is needed to overcome the handicap.

The expanding vocational rehabilitation program of the Federal Security Agency makes it doubly certain that private physicians will be keenly conscious of reconstruction and placement of the handicapped in employment. Under this program federal aid is provided to enable state boards of vocational education and state agencies for the blind to furnish disabled persons with all services necessary to render them employable or more advantageously employable. These services include medical and surgical care, hospitalization, physical and occupational therapy, prosthetic appliances, vocational counseling and training, maintenance during training, occupational tools and equipment, and placement in employment. Except for certain groups of war-disabled civilians and federal employees injured in line of duty, persons receiving physical restoration services or maintenance grants must be in financial need.—JAMA, May 27, 1944.

REPORT OF CIVILIAN EYE, EAR, NOSE, AND THROAT SPECIALIST WORK ON INDUCTION BOARD, U. S. ARMY, DETROIT, MICHIGAN

The committee was formed in December, 1940, and the work was started in January, 1941. The examinations were done at the Light Guard Armory with two men working each morning, starting at 7:30 and usually finishing before noon. When less than 100 men were to be examined only one man was called. The original group consisted of Drs. H. U. Mair, Harvey E. Dowling, Fred A. Lauppe, R. E. Anslow, W. S. Summers, Arthur S. Hale, John M. Carter, A. P. Wilkinson, James T. O'Hora and William S. Gonne. Before the year was over, Drs. T. Y. Watson, J. M. Sutherland, A. O. Brown, A. E. Vossler, L. Rubright, D. A. Cohoe, J. B. Morton and T. P. Clifford were added to the list of examiners.

Early in 1942 the committee was moved to the examining station on West Fort Street. Due to the increase in numbers examined many more doctors were called upon to serve, and two shifts were instigated. These two groups worked from 8:00 A.M. to 12:00 and 12:00 to 4:00 P.M. Again in 1943 the committee was moved to a new station at McDougall and East Jefferson Avenue. Still more examiners were required and the numbers examined each day were increased considerably. Now, in 1944, the name of the station is changed from an Induction Center to that of an Examination Center and it will be a very busy place due to reclassification and the fact that the physical examinations by pre-induction locations have been discontinued. There are now three shifts of examiners daily and the inductees who pass the physical examination are placed in a pool of either the Army, Navy or Marine Corps and are subject to call after three weeks.

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Table of Contents

Address of Welcome.
Claude R. Keyport, M.D. 557

Newer Trends in Industrial Sanitation.
Mohe H. Solworth 558

The Psychiatric Approach to Current Mental Health Problems in Industry.
L. E. Himler, M.D. 564

Prevention of Epidemics of Dermatitis in Industry Including Dermatophytosis.
Samuel M. Peck, M.D. 568

Criteria for Employability of Individuals with Lung Pathology.
Charles-Francis Long, M.D. 574

Reconditioning Problems for Disabled Veterans.
Marion W. Jocz, M.D., and *John J. Prendergast, M.D.* 577

Ocular Pathology Due to Organic Compounds.
Melvin H. Pike, M.D. 581

Penicillin in Surgery.
John Winslow Hirshfeld, M.D. 584

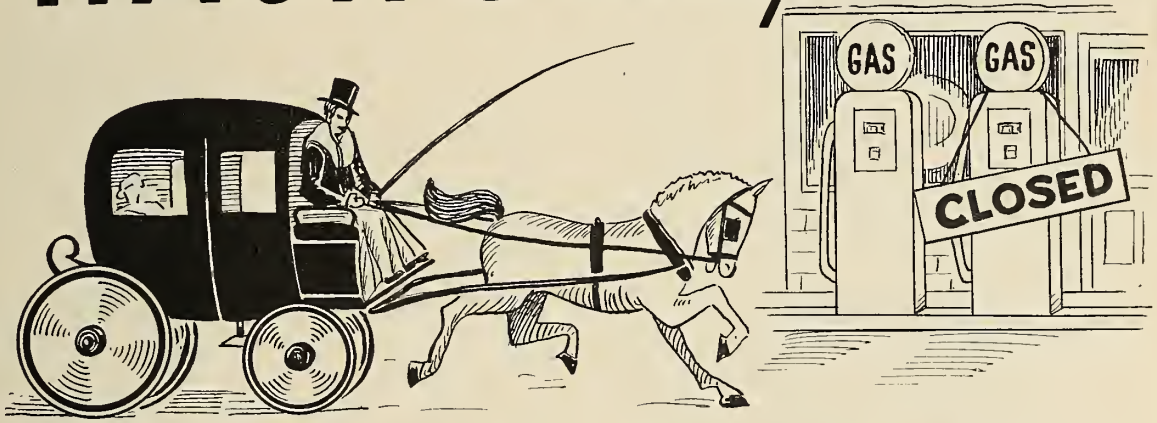
President's Page.
Is There Another Side to Medicine? 589

Editorial:
Postwar Plans 590
Doctors for the Postwar Period 591
Radio and Patent Medicines 591
Industrial Medicine and Surgery 592
Attention! 592

The 79th Annual Session:
Official Call 593
House of Delegates—Order of Business 594
Delegates to MSMS House of Delegates 595
Reference Committees 597
Proposed Amendments to Constitution and By-Laws 598
Committee Reports 599

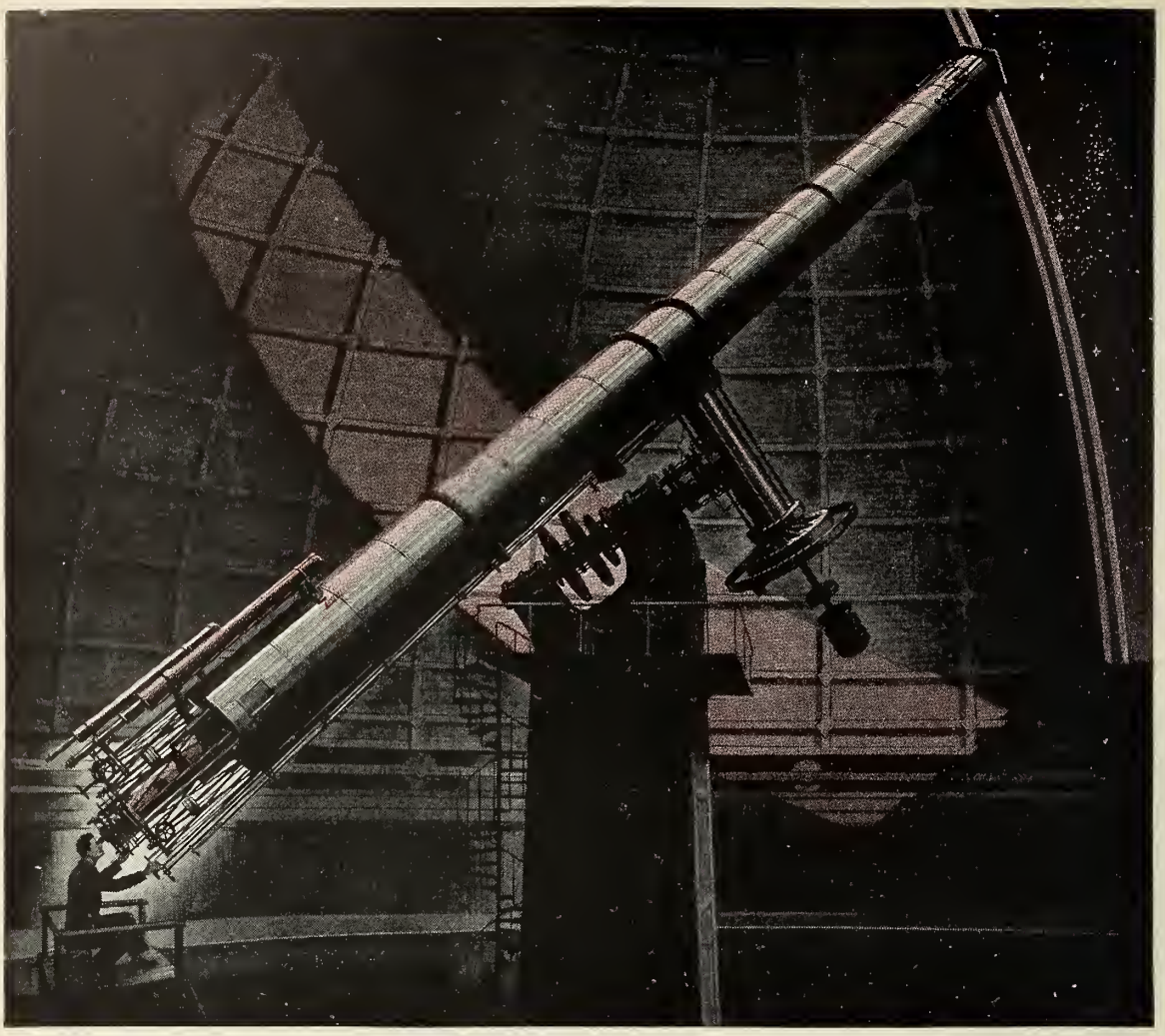
You and Your Business 602
Michigan's Department of Health 604
Woman's Auxiliary 606
Correspondence 608
County and Personal Activities 610
In Memoriam 616
"American Medicine"—MSMS Radio Program 623
The Doctor's Library 619
Political Medicine 534
War Medicine 538

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The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

Volume 43 July, 1944 Number 7

Address of Welcome

By Claude R. Keyport, M.D.
Grayling, Michigan



President of the Michigan State Medical Society

Members of the Michigan Association of Industrial Physicians and Surgeons and Guests:

I am very happy to be here this morning and to say a few words of welcome to you. As you know, this is the second Postgraduate Industrial Medical and Surgical Conference sponsored by the Committee on Industrial Health of the Michigan State Medical Society, the Michigan Association of Industrial Physicians and Surgeons in coöperation with the Department of Postgraduate Medical Education of the University of Michigan and the Wayne University College of Medicine.

So that you all may be familiar with the personnel of the Michigan State Medical Society Committee on Industrial Health, I would like to again call your attention to the members of this committee:

Dr. K. E. Markuson, Chairman, East Lansing
Dr. H. H. Gay, Vice Chairman, Midland
Dr. A. L. Brooks, Detroit
Dr. Wm. P. Chester, Detroit
Dr. Henry Cook, Flint
Dr. W. A. Dawson, Dearborn
Dr. W. S. Harm, Detroit
Dr. C. R. Hasley, Detroit
Dr. F. T. McCormick, Detroit
Dr. C. D. Selby, Detroit

Industrial medicine as a true specialty has only been recognized as such in recent years. For many years if an employe received an injury, he was rushed to a surgeon for treatment and the surgeon automatically became an industrial surgeon. As time went on, many other phases were found to be very important in the field of Industrial Medicine. The industrialist not only wished to have his employes cared for in case of injury, but he learned that in order to obtain the maximum of efficiency and the greatest number of man-power hours from an employe, the said employe should be in the best of health. Further, the industrialist does not want his employes to be exposed to industrial diseases or occupational poisonings. On the other hand, labor equally demands the right to be employed in surroundings which are safe and as free as possible from these same industrial diseases and occupational poisonings.

Since our entry into World War II, greater demands than ever have been placed on industry and, just so, industry has placed more and more responsibility upon the Industrial Physician. With the comparatively small number of specialists devoting their full time to Industrial Medicine, it is quite natural that these men are associated with the larger industries of the nation,

Presented at the Second Annual Postgraduate Industrial Medical and Surgical Conference of the Committee on Industrial Health of the Michigan State Medical Society, Detroit, April 6, 1944

while the small manufacturer is about in the same position as the general practitioner of medicine who is not trained in this new specialty.

Last year when the first Postgraduate Industrial Medical and Surgical Conference was proposed, there was a question of just how well it would be attended since so many of our doctors were in the armed forces of our country and those at home so extremely busy; however, in the minds of Dr. Markuson and his committee, there was no doubt at all. It was most gratifying to know that the attendance was nearly twice as large as the committee had planned for.

I am happy to see such a large attendance today and I am sure that this meeting is going to be most beneficial to you men. I sincerely hope that the Industrial Health Committee of the Michigan State Medical Society will continue these Postgraduate Clinics and that each year more men from the ranks of general practice will avail themselves of the opportunity to learn more of this most important and rapidly developing field of medicine.

MSMS

Newer Trends in Industrial Sanitation

By Mohe H. Solworth
Louisville, Kentucky



Sanitation Consultant, Joseph E. Seagram and Sons, Louisville, Kentucky.

The Significance of Ordinary Dirt

Those of us in service industries seem often to have an humbler part to play in the business world than do manufacturers. Yet that very distinction permits us to regard critically the demands of those same manufacturers and of their consumer public because of our broader contacts. When a service demand comes into being or when it has developed into a complex operation, there will be sure to emerge consultants. I have the dubious distinction of being a consultant on DIRT, probably a new low in technical capacity!

Often garbed in many socially acceptable forms, for the most part harmless appearing, common dirt is the stuff I'm talking about. I do not even include specialized dirts—radium, cadmium, asbestos, cutting oils, silica, et cetera. I am spotlighting humble matter, which because of its comparatively hazardless nature, because of its chronic presence and ubiquitousness, is unsuspected and thus insidiously affects industrial life and operations—in short, ordinary dirt.

I am speaking of dirt which causes accidents—slippery oil on the floors, eye-irritating fly ash, fire-hazardous litter behind the staircase, explosive dust in the mill, electrocuting hose-water on the motors. Accidents thrive in dirt and disorder; and slackness in work habits—the human factor—is as much the result as the cause of poor housekeeping.

Dirt and health are incompatible. At the machine, dirty cutting oil plus dirty personal habits equal dermatitis. In the toilet, dirt carries alimentary filth on all the fixtures. In the air or on dirt-laden surfaces, dust acts as a vehicle for air-borne contagions. In the cafeteria dirt assumes many forms: the unclean hands of the food handlers, the improperly washed and stored dishes and utensils, the wild life in the form of cockroaches and rats, and the indiscriminate sprinkling of sodium fluoride in the pantry.

Plain dirt interferes with production. It may, through causation of accidents and illness at home or in the plant, keep men off the job. Or, by its presence it may so affect working conditions that the efficiency of men is reduced. Adequate light is fundamental to working efficiency of normal men; to the many millions having defective vision or older employes it is paramount. Dirt on electric fixtures, windows, and walls is the saboteur of light.

Mental attitude and morale are all-important in the output of the worker. Grimy buildings, filthy personnel facilities—restrooms, cafeterias, work areas, unkempt uniforms spell reduced interest and capacity. Yes, "morale is a lot of little

Presented at the Second Annual Postgraduate Industrial Medical and Surgical Conference sponsored by the Committee on Industrial Health of the Michigan State Medical Society, Detroit, April 6, 1944.

things" but none of these things is dirt. The Industrial Dirt-tax is high. It is exacted in the forms of depreciation, deterioration, breakdowns, compensation, insurance, illness, labor turnover, janitorial and sanitation costs, and insect and rodent depredations.

The dirt from industry carries far. It travels on the workmen to their homes. It travels in substandard products to the consumer. It belches forth from smoke stacks to mantle the community in soot and fly ash, millions of tons a year. It causes community ill-health, high living costs, lower real estate values. It breeds resentment and misunderstanding in the community where industry should be the leading force for good.

That's a lot of dirt, and enough for now. But it is an indication of the negative force draining and sabotaging industrial operations and growth. Against this all-pervasive, pernicious industrial strangulant we had heretofore marshalled no ameliorative counteractants. We scarcely recognized it as a significant problem. We perpetuated a sufferance toward what today is classified as part of "Corrective Sanitation"—a few unsupervised janitors without training, tools, or talent were supposed to remove the "infinite residue of social living" and working. This group, drawn from the lowest level of the industrial scale, was left to its own devices to rectify the mistakes of architects, engineers, and the slovenly work habits of fellow employes. No wonder that with so puny an attack against so insidious an adversary the results have been disappointing. In fact, our efforts and results have been so meager that many industrialists have accepted the accumulated dirt as an inevitable part and parcel of manufacturing.

This pseudo-sanitation, unorganized and uncontrolled, is rejected for many reasons—it was inefficient, wasteful, unscientific and unproductive. Moreover, it was ignorant of its functional position in industrial relationships, unaware of its potential force in industrial operations, and unconscious of its power for industrial good.

The New Profession

What to do about it? Well, this much we all know: American genius, once aware of the challenge to its world-famous industrial technique, will not be satisfied to sit idly by. Indeed, our faith in this technique already is being justified in the birth of a new profession—designed genetically to eradicate dirt. It is the profession to be known as Industrial Sanitation.

Quietly, purposefully, it is emerging from the intricate web of scientific knowledge, comprising chemistry and physics, medicine and psychology, government and methodology which makes up our vast industrial pattern. You will see it come forth this year, in full panoply, equipped to meet and overcome the ennervating drug of disorder—it will be, it is, the new stimulant of the industrial laboratory. This new profession is shaping into an organized body of knowledge and concepts with a philosophy, objectives, structure and functions. Its force is guided by a new principle, Controlled Sanitation. Controlled sanitation is simply a comprehensive modern medical diagnosis and treatment compared to the former chiropractic—astrological quackery method of handling, usually called "clean-up."

Our profession is not a panacea, but neither is it a voice crying in the wilderness. *The new industrial sanitation knows what it is doing.* It understands its problems—the nature of dirt and disorder, their omnipresence and continuous accumulation. It translates this understanding so that all industrial forces—management, technology, research, education—may be utilized in the endless war on dirt. It realizes that sanitation stands for something more than toilet-room cleanliness, polished floors, dust counts—that it reflects an attitude of mind, an appreciation of an advanced way of living and working.

Functions of Controlled Sanitation

Industrial sanitation embraces five important functions: Preventive, Corrective, Protective, Esthetic and Hygienic. Let us examine these critically one by one.

Preventive Sanitation.—Of these five, preventive sanitation is the keystone consideration, for upon its development and execution depend the level of achievement of the others. For example, to the extent that a good preventive sanitation program is effected, to that degree will the costly routine of corrective sanitation be eliminated. The program is predicated on the premise that much of the dirt and disorder can be prevented and need not be perennially cured by the cleaning operation. We are striving to develop preventive sanitation to the highest degree because it promises the maximum results.

Preventive sanitation may be divided into four

phases: Education, Architecture, Engineering, and Research.

Sanitation education reaches every individual in the plant. There can be no clean plants without clean workers. The efforts of even a trained sanitation department will be nullified if everyone in the plant does not contribute to the general plant cleanliness. To induce a coöperative attitude we have initiated a formalized program in which all of our employes take part. Through our classes we aid in the development of good work habits and improved personal hygiene. The use of slides, demonstrations and outlines in the lectures bring a new conception of personal and plant sanitation. When the employe is shown how much of this program is designed for his welfare and development—the provision of light, clean, attractive surroundings—the most modern facilities, the considerable scientific effort devoted to these aims and that not only he, but the plant manager, is also attending sessions and learning how to help keep the plant clean—his interest is quickened from a passive, sometimes negativistic, attitude, to an active participation. It is our job to maintain this mental excitement, unobtrusively, of course, among the entire personnel from manager to laborer.

After we have influenced the human element in our preventive sanitation effort we turn to architecture. Here we find that architects simply have not designed buildings which exclude dirt or which can be maintained economically. A rubber tile floor in the cafeteria kitchen will not stand up under the constant moppings necessary in this area. Subsequently the floor has to be replaced by a granulithic hard floor with drains. Few architects seem to understand that buildings need daily cleaning; consequently, as a result there never is sufficient provision for janitor closets or supply rooms. Though why the architect should overlook this thought when the buildings he creates are conducive to insanitation, escapes us. This oversight, this defection, has several resultant implications. The cleaning is more costly since the janitor has to cover great distances merely changing mop water, or else the job results will be poor because the man will be reluctant to walk the extra steps for fresh water. Where to put brooms, mops, cleaning tools, supplies? Why, nowhere. The architects forgot that small conveniently located storage closets would reduce the costly labor factor. The result: mops and brooms and buckets cluttering up the corners of the buildings adding to the unattractiveness which they were supplied to eliminate.

Sanitation now guides the architect in many considerations: cleanable floors, walls and windows; the elimination of horizontal dust-catching surfaces, the provision of flush moldings. We advocate the use of rounded corners for ease in cleaning. We suggest construction which will eliminate insect and rodent infestation. We are even designing model supply and water-change cabinets as prefabricated units for plants now deficient in this important facility.

In seeking the sources of dirt for preventive sanitation we turn to the engineer. The smoke stack erupting soot and fly ash is a considerable problem which must be solved if we are to maintain adequate industrial environments. Precipitrons, and other devices should be more commonly available after the war to remove this source of filth. Equipment in the factory should be designed to cause less dirt through spillage and leakage. The proper operation of these machines should be taught so that operators can run them in a cleanly manner. Moreover, machines should be constructed so that they may be cleaned more easily. The location of equipment and proper ventilating devices also affect this source of industrial dirt.

Research is primarily directed at preventive sanitation practice. We study fungicides for prevention of mold; floors for wear and appearance; paint for durability; cleaning products for effect on surfaces. Our engineers, chemists, and bacteriologists are continuously working in the direction of elimination of fundamental causes of insanitation rather than unpromising chronic corrective efforts.

Corrective Sanitation.—Corrective sanitation is the least productive of the functions of the new industrial sanitation. Even up-graded with tools, knowledge and research to a far more effective instrument for removing dirt and disorder, it serves to a great extent as an unnecessary function. The use of a lower paid group of individuals, usually called "janitors" to rectify the mistakes of engineers, architects and maintenance men is not acceptable as a permanent solution. But as long as human inefficiencies and different levels of achievement remain we will still require a staff for corrective sanitation. Therefore, we do not overlook the opportunity for improving

the quality and amount of work performed by this group. Promoting interest in wanting to work is our first consideration; how to work, our next. Time-motion studies for more effective coverage and lessened labor costs; the supply and use of proper chemicals for improved results and protection of surfaces; the supply and use of better tools—aid in the controlled elimination effort.

Sanitors are not the only group engaged in dirt removal. Operators are responsible for the cleanliness of their equipment and the surrounding area. Slovenly work habits are decreased when a man is made responsible for cleaning his own messes.

But dirt—its prevention and removal—is not our only concern. We are also interested in employe health, plant preservation, and industrial esthetics.

Conservation.—Our role in plant conservation and preservation stems from two considerations, protection and costs.

Surfaces wear, even when soil is not present. It is sanitation's function to protect finishes, fixtures, flooring, and equipment with coatings of wax, paint and polishes. Harmful cleaning products or methods must be eliminated. Floorings, for instance, are usually washed out through improper materials and procedures rather than worn out from usage.

Salvage of discarded materials is of national importance today. Many a plant is now operating because of a good salvage program which supplies the parts to sustain production.

A good protective maintenance program keeps buildings in adequate repair. Our sanitationists, supervisors, and sanitors are required to report leaks, spillings, rusting, broken windows, et cetera. These are repaired immediately before they magnify into serious complications.

Esthetics.—The almost inevitable results of cleanliness and order are sensory and esthetic satisfactions derived from a satisfactory and challenging appearance. In fact, much, if not most, of this world's cleaning is directed to the ideal, not of health, cleanliness or order, but appearance. In domestic and social life, keeping up with the Joneses and maintaining appearances are one and the same.

The new sanitation, however, has an industrial esthetic function beyond the enhancement which removal of dirt and disorder presents. Before their installation the sanitationist exerts an influence on the selection of walls, floors, metal decorations, color schemes, and lawns. The choice and placement of office furniture is also within his jurisdiction. Neat, attractive uniforms contribute further to the plant appearance. Moreover, through daily plant inspections, adherence to paint schedules and the follow-up of work orders insure the maintenance of esthetic standards.

If this profession is executing new functions, it is also creating responsibilities through its making possible new levels of environmental work atmosphere.

Willkie and Blankmeyer, in their forthcoming *Outline for Industry*, point out:

> "To sharpen the perceptions of men and women is to invite new hungers which demand more godlike food. When one becomes aware of the benefits of orderliness, he casts a more critical eye about his surroundings. Objects that once he took for granted as landmarks inherent to his environment become irritating and obnoxious. A path beaten across the grass by unheedful feet —a blatant calendar hung on the wall as a substitute for art—piping dodging across a room in haphazard pattern and supported by rusty iron straps—these, and a thousand more excrescences like them, impress their crudeness on the human mind. It is not too much to ask that buildings be pleasant to the sight, that lawns and shrubbery contribute to a setting which will endear a man to his labor. It is worth an initial effort to plan the location of equipment, and the expense of bringing its manifold arteries into a master control board, if these things will contribute to an atmosphere of dignity and reflection for the persons who inhabit it. It is obvious that these things are good public relations from a standpoint of making visitors at ease in the midst of operations. But it is far more important that those who work and those who administer, those who create and those who serve, find themselves in a way of life contributing to the formal precepts of civilization."

Can such a higher way of living be construed as other than beneficial as it radiates from the industrial scene to the home and the community, even to the closer neighbors of our coming world?

Hygienic Sanitation.—The fifth function of an industrial sanitation program is hygienic sanitation, the health protection and promotion of plant personnel.

For protection against contamination we clean and disinfect toilet facilities, lavatory and locker installations, drinking fountains and infirmaries. Athlete's foot control is within our departmental function.

Through preventive and removal measures we eliminate dust, and thus reduce the possibilities of air-borne contagions. Dust removal also serves to reduce eye and nose irritations and infections. The maintenance of the highest sanitary standards in the cafeteria—the care of the utensils, dishes, glasses; the habits of the food handlers; the storage of food and disposal of waste—are within our province.

Industrial sanitation assists in life conservation by entering into many phases of the safety program. In its housekeeping function it determines the correct storage positions for poisonous, inflammable or otherwise hazardous materials. By maintaining orderly and safe areas many falls and accidents are prevented. The removal of rubbish and trash minimizes fire hazards. The cleaning of windows and light fixtures provides safer work conditions. In many plants dusts are constant explosive possibilities. Sanitation and housekeeping are major factors in preventing such explosions.

The Comfort Level is also assured through sanitation's role in the advocacy of proper floorings, primarily for cleanability, but also for resiliency, appearance, and noise transmission. Wall surfaces properly selected likewise contribute the beneficial effects of glare-free color harmonies and reduced sound transmission. Sanitation also exercises some beneficial jurisdiction over light—windows, fixtures, paints—and ventilation. Thus, with many considerations in mind, the selection of comfort-increasing facilities, fixtures and furniture adds to the well-being of the employe.

Of greater significance to us than the protection against possible lurking micro-organisms is our role in the promotion of good health habits. The contraction of syphilis and gonorrhea from toilet seats is rather remote but the revulsion induced by filthy toilet arrangements which results in not using the toilets, is not remote. Invitingly clean facilities encourage good toilet habits. Not only provide them but keep them clean and you stimulate levels of clealiness resulting in lowered dermatitis incidence and increased health tone. Immaculate uniforms become translated into desire for cleaner street and home dress.

Cafeteria sanitation has more than a protective function in the cafeteria kitchen. In the dining room, cleanliness, orderliness and pleasant surroundings encourage the worker to eat and benefit from his food in the safe company cafeteria rather than the unregulated "Greasy Spoon."

Happily, there is a rising emphasis on industrial health education. But health education without the "health atmosphere" of a challenging environment is incomplete. Sanitation, however, does not content itself with physical equipment and its potential influence on the habits of personnel. It actually promotes instruction. Personal hygiene education in our plants was initiated originally for environmental reasons. But environmental sanitation has for one of its important objectives the protection and promotion of the health of the personnel. Each end is mutually dependent and cannot be successful without the other. Their interdependency assures a concerted attack promising higher achievement.

The health habits promoted by the plant will not be confined to the plant. They will tend to be transferred to the home and community of which the plant is a part.

The picture will be balanced. How a man lives and where he lives markedly affect his activity (both in quality and quantity) in the industrial plant. His productive capacity, his efficiency, his thinking processes, his health, his accident incidence, are considerably affected by the home factor.

Enlightened industrial sanitation can help achieve the higher capacity levels by serving as an environmental model and promoting the formation of better health habits.

Industrial Sanitation and Industrial Medicine

The reasons for industrial health programs are greater now than ever before in our history. The opportunity for the industrial health movement will be vastly greater in the future. The growth will be based on the control and solution of the problems incident to industrial health. The control will depend on the utilization of the new tools available. One of these tools is industrial sanitation.

This new endeavor, industrial sanitation, is going to clean up the industrial environment. It is going to reduce costs, boost production, insure safety, and protect and promote personnel health. It is going to affect industrial operations, the individual, the home, the community and the nation. With your guidance and direction it will do a more effective job more quickly. Why not

take advantage of this new industrial aid? Why not put this new but growing industrial force, its research and technical development to work under your auspices?

In the prevention of industrial illness there must be an integrated program of attack. Sanitation is only one of the factors but it should not be overlooked. To the extent that this new program is effective—and its utilization of architecture, engineering, education and research insures its reaching a new level—to that degree will many of the curative functions of industrial medicine be outmoded. Fewer accidents, less illness, higher morale—yes, even better home conditions will contribute to a higher degree of worker health levels.

In all industrial health codes and delineations of a plant physician's duties, plant sanitation is always included. Yet how many physicians are intimately acquainted with the plant conditions, the organization or technology dedicated to the housekeeping and sanitation in their plant or the new dynamics and conceptions which could be utilized in a controlled sanitation program so vital to the productivity, health, and safety maintenance of their personnel?

In the future the results of the entire health program will be more measurable, and the plant physician with an effective comprehensive program which results in high industrial benefits and low compensation, absenteeism, accidents, and other drains, will be of greater aid to industry and in greater industrial demand.

Sanitize (I was about to say "clean," but the new sanitation is more than cleaning) your plants the new way and you'll have a healthier, safer, happier personnel. Moreover, while achieving the objectives of human maintenance and productivity you'll be accomplishing some other equally important ends—higher machine efficiency and production, reduced costs, enhanced plant appearance, and elevation of industry's role in the community.

Our purpose is not to increase the duties or responsibilities of plant doctors during this war period when we are so handicapped for industrial physicians.

We are suggesting assistance in the person of the Industrial Sanitationist and an improved staff to eliminate physical and psychological health deterrents in the work environment and promote health habits through immaculate, safe lavatories and locker rooms, uniforms, inviting cafeterias, and sanitary infirmaries. The training and scientific study requisite to the new industrial sanitationist would make him an extremely valuable adjunct in a health program. The very nature of his work takes him and his staff to every corner of the plant. The preventive purposiveness of his work is designed to remove health and morale reducers before they may be serious.

The New Interpreters

One project included in the future planning of industrial sanitation is the provision of trained personnel for industry. The most essential need calls for the new professional, the industrial sanitationist. To supply this need there is planned a postgraduate school and research center for engineers, chemists, and similar technical students. The plans are for immediate inception right after the war. At present a campus location in Louisville is being chosen for the school. The probable enrollment will be composed of about twenty-five students with the prerequisite technical background. The course, consisting of an intensive year's training, will include Bacteriology, Chemistry of Cleaning, Soaps, Detergents, Wetting Agents, Materials, several Engineering Studies, Time-Motion Projects, Architecture, Landscaping, Industrial Decoration, Personnel Management, Personnel Coördination, Teaching Methods, Statistics and Records, Cost Control, Safety, Industrial Hygiene—all specifically treated with respect to industrial sanitation. There will be actual industrial laboratory work, research problems, and emphasis on writing of reports, for the new profession must be articulate.

The faculty will consist of several industrial sanitationists, and professors from the universities within the immediate vicinity, the Universities of Louisville, Kentucky, Indiana and Purdue. Also, we hope to attract national leaders from industrial medicine, industrial hygiene, safety and other related professions to visit us for seminars devoted to their particular specialties so that the students may gain the richest preparation for top-notch execution. The students, whom we shall select carefully, will not only receive this intensive detailed training by industrial practitioners but will also work for three months in industry, with pay, putting in practice what they have been learning while also becom-

ing accustomed to industrial values and arrangements. They will become familiar with the manufacture of products used in their profession by actually assisting in the compounding and processing in a model plant.

Our graduate will be a capable figure. He will be able to demonstrate with his hands—he will be a craftsman; he will plan and execute his program—he will be an executive; he will be an efficient leader and handler of men—an industrial diplomat; he will utilize science and scientific methods to achieve his objectives—a scientist; above all he will be a well rounded, industrially apt professionalist, not a hothouse theoretician.

One further practical aspect—there will be excellent jobs waiting for the new industrial sanitationist. Nor will his study and scientific development cease upon graduation. He will maintain contact with the school through individual in-service research projects the results of which will contribute to the knowledge of all. Refresher courses will be available to maintain technical grasp.

Soon, this industrial field will no longer be without adequate information sources. Books will be available to supply background and technological information on every phase of plant sanitation. A journal of *Industrial Sanitation* will serve as a monthly exchange center for original research and articles of current interest by leaders in this and related professions.

External Aspects

Industry is much broader and more pervasive than a mere building and machinery and workmen. It is a factor of society coöperating and interlocking economically with all the rest of society and contributing to that society.

But its economic character and relationships are not the whole of industry. The moment it touches government it assumes a political nature, and through its own personnel, as well as through its socially useful product, it is a social institution. It creates a community of social and domestic life in the factory neighborhood. It is a community of social life within the factory walls. These communities cannot be separated one from another. The industrial efficiencies, habits, morale of the workers—who spend fully half their waking hours at the plant—are inevitably carried home and translated in greater or less degree in terms of domestic well-being and happiness. Industry as an economic factor cannot retire into this isolated aspect of itself and be nothing more. It is much more. It touches the life of the nation at many points.

Industrial sanitation is one of the new building stones with which a permanently successful industry can be erected; on the one hand through improved operations and increased profits; on the other, through the altruistic leadership demanded of industry today in our democracy. The dominant role of industry can be assured only through a more enlightened self-interest and the most practical and intelligent altruism.

Industrial leadership implies a responsibility for standards of living, working, housing and community excellence and thus affords an opportunity for great national good. We believe by providing an environmental model, industrial health education, the most modern facilities, and by leading the way in removing health nuisances —industry may discharge its responsibilities in this direction. Controlled sanitation, the new industrial instrument, is available to contribute its expanding force in support of industry's role.

MSMS

The Psychiatric Approach to Current Mental Health Problems in Industry

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■ As Dr. Frank F. Tallman stated at this conference a year ago, psychiatry and industry must learn to speak the same language if they

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are to work together successfully. Industry justifiably expects psychiatry to translate its thinking into concepts which management can understand, and welcomes evidence that psychiatric methods can bring about desired improvements in industrial human relations. In some respects the psychiatric approach is itself in the process of being "retooled" to fit into this relatively new setting. The task immediately before the industrial psychiatrist today is that of an integrator who coördinates the contributions of medicine, psychology, social case work, and education, so that they can be made to bear effectively on the personality, adjustment, and productivity of the individual worker.

Ample statistical evidence is available from institutional, extramural, and military psychiatry to indicate how great industry's stake is in the mental health of its workers and potential employes. Considering first only those individuals who develop serious mental disorders, a recent study in New York state revealed that one person out of twelve can be expected to spend some part of his life in a mental hospital. With reference next to the less severe nervous conditions found in the civilian male population, a study of 300 Wayne County selectees made in the summer of 1943 revealed that the proportion rejected for neuropsychiatric and psychosomatic disorders together reached slightly over fifty per cent. Furthermore, of the 70,000 World War II veterans now being returned to civilian life each month, at least 25,000 are neuropsychiatric casualties.

It is thus apparent that from both the rejected and the discharged groups, one-third to one-half of the men now being made available for employment have some type of mental health problem which would interfere with their usefulness to the armed forces. Naturally all of these men are not by the same token unfit for industrial employment. Among the 300 Wayne County rejectees mentioned, 88 per cent were employed at the time of their examination and expected to continue in their jobs. While accurate figures are not available at this time, it is probable that the proportion of employable men discharged from military service will fall somewhat below that number. In any event, it is inevitable that many of those who developed nervous and mental symptoms under military life will have readjustment problems of some degree when they return to their peacetime jobs. At the present time there is no reason to doubt Giberson's estimate that one man out of every five employed in industry would profit from psychiatric guidance and control.

As Anderson has said, the task of psychiatry in industry is much less that of providing clinical services for individual problem workers than it is to integrate its techniques with all personnel procedures connected with employment, placement, training, promotion, or discharge of employes. Psychiatrists must teach and provide clinical training in a point of view which will constructively influence human relationships on all levels of the industrial hierarchy. The point of origin from which this influence should radiate is logically the department which supervises medical and personnel work. Here the psychiatric approach can be effectively worked out in collaboration with those who are already concerned with human relations—the employment manager, the safety director, the women's counsellor, foremen, union committeemen, and executives in charge of in-plant training.

So far as medical therapy in individual cases is concerned, as Doctor Selby has stated, industrial physicians are as aware as general practitioners of the fact that every patient who consults them has in some degree a mental hygiene problem, and in so far as physicians take opportunity to listen sympathetically to the men and women who consult them, they are already employing a very practical type of psychotherapy. The skillful physician knows how to dispel apprehension over symptoms which have no significance medically. He realizes the importance of attention to personality factors in accident-prone workers. Insufficient time, and occasionally a too narrowly restricted interest in purely organic aspects of illness are the chief limitations to the industrial physician's function as psychotherapist. The training of nurses could also be extended to include more work in this field.

But beyond this, industrial psychiatry as a specialty must concern itself with a wider variety of personnel problems than those which come directly or indirectly to the attention of the medical department. Many major and minor mental health problems may lie concealed under other organizational or production troubles and these come to the physician only incidentally if at all. Absenteeism and turnover are two of the

more widely publicized perennial industrial problems in this category. Poorly handled personnel problems all too frequently terminate with employment obituaries such as "bad work habits," "dissatisfied with every job given," "antagonizes everyone in the department," "frequently late," "no interest in the work," "too many personality clashes," or "refuses to take orders." Studies of such job separations reveal again and again that personal and social maladjustment is much oftener the cause than lack of occupational skills. As Dr. Ralph Lee might say, it is "humanics" rather than "mechanics" which lies at the bottom of so many industrial ills. So far as it is humanly possible, our task is to get rid of the symptoms rather than the employe.

The great amount of wasted effort, expense, and blasted hope which results from improper selection is too well known to need re-emphasis here. It is because of this that the employment office offers one of the most strategic spots for the utilization of psychiatric techniques. Employment managers are keenly aware of the necessity of improving their selection methods, no matter whether they are drawing from the top or the bottom of the labor market. Successful selection and placement depend on "the ability to recognize ability," and a capacity for judging skills and appraising personality attributes along with physical health factors. Working as a team, the physician and employment interviewer must frequently make decisions concerning the same borderline psychiatric conditions which the induction station psychiatrist must prevent from entering military service. In this category are applicants with marginal intelligence, tendencies to alcoholism, psychopathic personality, epilepsy, various types and degrees of psychoneurosis, and pre- or post-schizophrenia. Unstable, inefficient, undependable and poorly integrated personalities do not come labeled as such—on the contrary, they sometimes manage to obtain good recommendations which are intended to help them. It can be readily seen that some practical orientation in psychiatry is essential if employment practices are to be conducted on a truly efficient basis.

The obligation which industry has assumed in regard to employing discharged servicemen has placed a new responsibility on the employment interviewer and the medical examiner. The absence of information beyond the man's own statement concerning the cause for discharge presents perplexing problems to prospective employers. The only safe procedure to adopt in this situation is to thoroughly examine each individual applicant, using the full case study method, with special attention to personality-determined factors. Knowledge that a man has been dicharged under Sections 2, 8, or 10, or that he had "psychoneurosis, mixed type," should not prejudice the interviewer against the man's eligibility for employment. It is as true of mental and emotional as of physical disorders that not all conditions which render a man unfit for military service will necessarily interfere with industrial adjustment. This is particularly true of psychoneurosis, which comes first among all medical causes for military discharge. The employment examiner's duty is clearly one of judging each man on his individual merits, and this task is greatly facilitated by even an elementary understanding of psychiatric principles.

Industrial physicians as well as all others who make decisions concerning employment have need for simple, efficient, and practical selection techniques which are not unduly time consuming. Aside from the physical examination, the three instruments commonly used for this purpose are application blanks, psychological tests, and personal interviews. It is my opinion that application forms, no matter how detailed, and precision tests, no matter how ingenious, can never adequately substitute for good interview technique. Effective employment interviewing presupposes both academic and practical training in the diagnostic techniques of psychiatry. Certainly much more is involved than witness-stand cross-examination, trick questions, or mere passive listening. The basic information necessary for an employment personality appraisal falls into the same five or six categories that are used by the psychiatrist in considering a man's suitability for military service. These include his educational record, his previous work adjustment, his physical and mental health, the family setting and influences, and the applicant's attitude toward the prospective job.

By a streamlined adaptation of the case history method, and by employing the clinician's way of looking, seeing, listening, and, so to speak, feeling himself into the applicant's place, the trained observer gets an insight into fundamental motives, habits and intentions which far

surpasses stereotyped question-and-answer procedures. The truly diagnostic interview has a three-dimensional quality, with an ear to past conditioning factors and an eye figuratively on future implications, while the hands are intimately in touch with the presenting situation, drawing out and "sampling" typical personality reactions. Interviewing in such a manner makes it possible to construct, appraise, and utilize, as it were, a "human flow chart" which gives a scientifically valid basis for judging and predicting the outcome of behavior.

The Interview

From what has been said above it is evident that effective interviewing techniques are essential to all industrial personnel functions, and this is even more true when the aim is to change attitudes and habits, that is, when the therapeutic aspect is the primary consideration. Interviewing the returning absentee can be used to illustrate this point. The success of such an interview depends not at all upon making the worker feel he is "on the spot" and in this way extract from him the "real" rather than the "cooked-up" reason for absence. On the contrary, the worker must be made to feel the interviewer's conviction that absenteeism by and large is a symptom of the worker's attitude, and that from this point of view management has a keen interest in knowing how absence reflects on its policies and procedures, so that effort can be made to remove or correct causative factors. The atmosphere which the interviewer strives to create is that of the consulting room, not the courtroom, and the worker must feel that a checkup on attendance, like taking his pulse, is motivated by a genuine interest in his behalf. Attendance records in industry are as indispensable as temperature charts in medicine, and any elevation in nonreported absences should be regarded as a sensitive index of declining morale. Obviously when there is an epidemic of absences in one department, the supervisor may be the disease vector. The trained interviewer not only avoids stirring up resentment in workers who have a legitimate excuse and a good previous attendance record, but by recognizing these factors he conveys a sense of management's pride in the regular workers.

It is to be hoped that industry will not overlook the true significance of attendance problems after the current war-inspired interest has subsided, for to do this would be equivalent to discarding what is now a valuable indicator of plant morale. Reminiscent of post-mortem examinations in medicine, properly conducted exit interviews can also bring into sharp focus certain selection and management practices that have failed. It should be emphasized, however, that attendance and exit interviewing must be done by one who is not only thoroughly familiar with plant practices but is also adequately trained in the correct technique, otherwise the contacts will be ineffectual and the data gathered will be of little more value than that obtained by ordinary questionnaire methods.

Disturbed human relationships within a plant are apt to come first to the attention of supervisors and foremen, just as in military service behavior maladjustments are first discovered by the line officers. Understanding of the psychiatric approach in interviewing would be greatly helpful to such minor executives in their on-the-job relationships. The job relations training courses now in vogue have made many foremen keenly aware of the importance of human relations in their daily work, but have also made some sensitive to their limitations. Others have protected themselves from mistakes by taking recourse to overformalized contacts with their men. In order to gain fuller understanding and confidence in specific interviewing procedures, foremen should have opportunities for on-the-job consultational training in the handling of actual cases. Direct experience gained in applying and modifying their own techniques under apprenticeship type of guidance would stimulate closer contacts between foremen and the varieties of personalities they seek to control and direct.

Among returning war veterans there will be a certain number who are still in the process of recovering from the effects of the physical, mental or emotional trauma they have undergone. From preliminary observations it would appear that as many as two out of five will have at least a temporary period of impaired work adjustment. Some of these men will show heightened sensitiveness, more than usual restlessness, dissatisfaction, discontent, and occasionally an attitude of defiance toward accepted procedures. A few will feel entitled to special privileges and make issues out of minor disagreements. Some

will be handicapped by neurotic reactions, a few younger, immature youths will be frankly spoiled, and another group will reflect negative conditioning toward the psychiatric approach because of their military experiences. In all contacts with such men, emphasis should be placed on the need to appreciate and accept them for the positive assets they possess, rather than what they lack. Relationships on the job may at times be difficult or delicate, progress may be slow, and in certain instances cautious modifications of management procedures will be necessary, but complications of this type only serve to re-emphasize the importance of sound interviewing techniques. Foremen should give special attention to the work adjustment of returning servicemen during the uncertain and sometimes trying "break-in" period.

Interviews which touch on deeper emotional material can be compared in some ways to a minor surgical procedure, such as opening a subcutaneous abscess. While the drainage provided may give immediate relief, arrangements for follow-up visits are necessary until the wound has healed and all complications have been prevented. It is unfortunately true that occasionally some symptoms (such as drinking) are apt to be increased as if in protest to any step which brings underlying conflicts uncomfortably near the surface of conscious awareness. Such difficulties may arise for instance in inadequate, alcoholic, paranoid or constitutionally defective personalities, or other marginal workers who tend to make up the relatively small group responsible for a disproportionately high percentage of absences, discharges and quits. Situations of this kind serve to illustrate the limitations of therapeutic interviews in the industrial setting, and the necessity of referring individuals having deep-seated mental health problems to community personnel and agencies offering psychiatric care.

In conclusion, while psychiatry does not offer ready-made solutions to industry's manifold problems, in the field of human relations it does offer an approach and a technique for constructively influencing interpersonal contacts on all levels of the industrial social pyramid. Diagnostic and therapeutic interviewing techniques are not only being tooled to meet industry's changing needs, but they can be taught and effectively demonstrated "on-the-job."

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Prevention of Epidemics of Dermatitis in Industry Including Dermatophytosis

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■ Nearly all of the cases of industrial dermatitis are due to chemical agents. Physical agents and bacteria including the higher fungi play a minor role.

In order to prevent or control an outbreak of industrial dermatitis it is necessary to have a sound knowledge of (1) the industrial process, i.e., the worker's industrial environment; (2) the chemicals encountered by the worker which are capable of producing a dermatitis, and (3) the mechanism by which these chemicals produce the dermatitis. With these facts thoroughly under-

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stood, logical methods for prevention, control and treatment can be instituted.

While most of the phases of a control program can be worked out by the industrial physician, other phases need the coöperation of the industrial engineer and the chemist. In planning our program, we must always bear in mind that the coöperation of the worker is essential. Proper instruction of the worker in the best possible use of the preventive equipment should be a part of the program of prevention. In many instances the last can only be accomplished by continuous supervision.

It is almost superfluous to state that a proper appreciation of a worker's industrial environment can only be made by plant visits. Yet many physicians attempt to diagnose and treat industrial diseases without once inspecting the factory where their patients are employed. Even when the industrial hazards which may produce dermatitis are apparently well understood and seem to be well controlled, outbreaks of dermatitis may still occur due to a change in processes so that the known irritants are being contacted in new ways. In some instances, irritants which were infrequent causes of dermatitis become important factors in dermatitis production because of the sudden acceleration or expansion of the work so that greater exposure occurs among more workers. The foregoing explains the importance of frequent revisits to the plant in order to prevent outbreaks of dermatitis.

The industrial physician should be well versed in all of the dermatitis-producing potentialities of the chemicals with which the worker comes in contact in the plant under his supervision. The constant introduction of new chemicals with which he is not familiar often makes this difficult. When such unknown chemicals are introduced, there should be a practical plan available by which the dermatitis-producing potentialities of the new chemical can be studied.

It is of paramount importance that the physician becomes habituated to think of his industrial chemicals as belonging to one of two classes. They are either primary irritants or sensitizers. Primary irritants may also be sensitizers.

A primary irritant has been defined as follows:[8] "A primary cutaneous irritant is an agent which will cause dermatitis by direct action on the normal skin at the site of contact if it is permitted to act in sufficient intensity or quantity for a sufficient length of time."

Most of the dermatitis encountered in industry is due to primary irritants. Strong primary irritants such as sulphuric acid or nitric acid and other caustic substances while they cause sporadic cases of dermatitis rarely lead to large outbreaks. This is due to the fact that their dangers are readily recognized both by the workers and the plant management. They cause dermatitis by accident or under unforeseen circumstances which are readily remedied.

It is the dilute primary irritants or those which are contacted intermittently which are slower and more insidious in their action and which are often responsible for the large numbers of cases of dermatitis which can be referred to as epidemics. Before such outbreaks can be prevented and controlled, the mechanism by which they produce pathology must be understood. Two such examples are the cutting oils and the solvents which are worth while discussing because it illustrates how necessary it is to understand the mechanism by which they produce dermatitis to institute a proper program of prevention. We know that cutting oil folliculitis is most frequently found after exposure to the insoluble cutting oils.[6] These consist essentially of a large percentage of petroleum oil to which is added a small amount of animal and vegetable oil, chlorine compounds, sulphur and an inhibitor to prevent deterioration of the fatty oil. We know also that the cutting oil folliculitis per se is not due to pyogenic bacteria and they do not live in insoluble cutting oils. Once this fact has been learned, we no longer need antiseptics in the cutting oils to prevent this occurrence. In fact, the addition of an antiseptic to a cutting oil increases the dermatitis hazard because an antiseptic itself may irritate or sensitize the skin.

Clinical experimental and histologic studies have shown that the petroleum hydrocarbons after prolonged contact have the property of producing hyperkeratosis of the epidermis which leads to the formation of the comedo.[6] The sulphur and chlorine compounds in the oil are capable of causing inflammation around the hair follicles. Bacterial infections of these lesions causing boils, etc., are complications rather than original causes and the bacteria come from the surface of the skin or from soiled clothing. Bacteria also gain entrance into the skin through

tiny cuts and skin punctures produced by metal slivers from the use of dirty waste for cleansing purposes.

The soluble cutting oil bases mainly used for making cooling compounds consist of sulphonated mineral and fatty oils 60 to 90 per cent, soap 5 to 30 per cent and volatile contents 0 to 10 per cent. Lately we have learned that some of the soluble cutting oil bases are being chlorinated and are causing dermatitis because of this fact. Inhibitors such as phenolic amines are added to the soluble oils to prevent rancidity of whatever fatty oils they contain.

Soluble cutting oils as a class do not cause dermatitis as frequently as the insoluble oils, but if they contain sufficient amounts of sulfonated mineral oil, they may defat the skin causing a chronic dermatitis, and if they contain large amounts of antiseptics or chlorine they may cause allergic dermatitis.

There are instances when allergic contact dermatitis is caused by both soluble and insoluble cutting oils due to the phenolic amines or other irritants but that is infrequent compared to the other types of dermatitis caused by them. The insoluble cutting oils defat the skin and produce changes such as will be discussed under solvents.

The solvents cause changes on the skin slowly if contact is intermittent.[2,4] If the mechanism of dermatitis production is not understood the early changes which they cause may be missed and large numbers of workers may be affected.

A solvent dermatitis presents a very typical picture. The solvents tend from their nature to remove the natural fats and oils from the skin. They cause a progressive series of changes in the skin dependent on the duration of exposure or whether the skin is dry or oily to begin with and on the character of the solvent. The solvents include petroleum derivatives, coal tar derivatives, turpentine, alcohols, etc. The hands, wrists, and forearms are usually affected. If the fats and oils are removed faster than they can be replaced by the skin glands, they first lead to a dryness of the skin, the skin markings become accentuated, the dorsum of the hand may become reddened, scaly, and fissures may appear over the joints of the hand and at the base of the nails. As the process continues, the keratin becomes dissolved and vesicles may be found. Proper care in the early stages by inspection of the hands of the workers exposed to solvents often forestalls outbreaks of solvent dermatitis. It is well to inspect the hands of these workers from time to time in order to find early cases and to see whether the safeguards indicated are properly carried out.

Sensitizers cause only about 20 per cent of all contact dermatitis. The sensitizers can be defined as follows:[8] "A cutaneous sensitizer is an agent which does not necessarily cause demonstrable cutaneous changes on first contact but may effect such specific changes in the skin that, after five to seven days or more, further contact on the same or other parts of the body will cause dermatitis."

Unlike the primary irritants only those workers would need protection who we know will become sensitized, but it is impossible to foretell this. However, once we know that we are dealing with a strong sensitizer protective measures should be instituted which are as thorough as those dealing with the primary irritants. The concentration of the sensitizers as well as the period of exposure will not only determine the number of cases of sensitization encountered, but the severity of the eruption as well.

It is important to know that not only the concentration of the irritant plays a role in sensitization, but its physical state as well. In order to produce sensitization the irritant must be soluble or it must be brought in intimate contact with the skin. It must "wet" the skin. Thus a condition which produces increased perspiration, such as in the summer, results in more of some sensitizers being dissolved in the skin and thus more cases of dermatitis. Friction is another factor which contributes greatly to sensitization or even primary irritation by bringing about more intimate contact between the living cells of the skin and the irritant. These facts must all be taken into consideration when we plan our program of prevention and control.

Patch Test

What is to be done when a new chemical is introduced as far as gauging its dermatitis-producing potentialities. This chemical may be a primary irritant or a sensitizer or both. A primary irritant can be determined by its action on the skin of laboratory animals. If the chemical is found not to be a primary irritant, the following procedure is suggested to determine whether it is

a sensitizer. It has been called the *Prophetic Patch Test* by Schwartz and Peck, and has been employed by them to prevent dermatitis among our population in the introduction of chemically impregnated clothing such as fabric finishes, cosmetics, et cetera.[7]

The test is carried out on 200 or more individuals in the usual way. Since the chemicals or compounds to be tested are new ones, the subjects tested have had no previous contact with them, and therefore cannot be sensitive at the beginning of the test.

Two series of patch tests are carried out on the same individuals ten to fourteen days apart. The first series of tests would give reactions only with a primary irritant, or with people who have been sensitized by previous contact with the chemical. The second series shows the number sensitized by the first series. Experience has shown that even one positive reaction among the second series may indicate that the test substance is a sensitizer which might lead to outbreaks of dermatitis if allowed to be used by large groups of people.

In actual industrial exposure there certainly would be greater contact for a longer period of time and over greater areas of skin than there would be under conditions of the patch test. Also, other factors such as friction, et cetera, play an important role in bringing about greater and more intimate contact between the industrial irritant and the living cells of the skin.

Now that the first phase of prevention, and an idea as to the method of action of some of the chemicals have been discussed, we will briefly discuss and enumerate the actual preventive measures.

Preplacement Examination

Pre-employment patch testing is not advisable. Workers are not allergic to chemicals with which they have had no previous contact. It is only useful as a diagnostic measure in those workers who give a history of a dermatitis in previous employment where the same chemical contacts are present. Even a positive patch test does not mean that the worker should not be employed. We have learned that "hardening" often occurs if the worker is allowed gradual and supervised contact with the chemical to which he is sensitive. This is important in these days of labor shortage.

Applicants with certain skin eruptions should not be employed where there are marked skin hazards because their normal protective barriers such as a normal intact keratin layer is missing and they are thus more sensitive to the action of both primary irritants and sensitizers.

Applicants with dry skins should not be given employment where they are exposed to solvents since they may readily develop solvent dermatitis. If they are employed, special care must be taken of their skins.

Proper Hygienic Working Environment

If complete prevention of contact between the worker and the irritant were possible, the ideal arrangement to prevent not only industrial dermatitis, but systemic poisoning as well would be present. To do this the manufacturing process would have to be totally enclosed. While this is not possible in most instances general and local ventilating devices can be installed to draw irritant dusts and fumes away from the worker. This phase of prevention is the field of the industrial hygiene engineer. Some writers not familiar with industry have advocated substitution of harmless chemicals for those that cause dermatitis; you who are familiar with industry know how absurd such recommendations are.

The workroom should be kept scrupulously clean. The floors, walls, and ceilings of workrooms in which there are industrial irritants should be cleaned daily. Proper protective devices such as metal aprons on machines and filtering devices to remove slivers in the case of cutting oils, etc., should be installed to avoid as much contact between the workers and the irritants as possible. The machines and tools soiled with industrial irritants should be cleaned daily.

Protective Clothing

Protective clothing properly made and intelligently used by the worker is of great value in the prevention of occupational dermatitis. Emphasis should be placed on the protective clothing which is to safeguard that part of the body particularly exposed and should be designed to protect against the particular chemical encountered.

Closely woven fabrics are imperative where there is an exposure to irritant dusts. Not only coveralls constitute protection, but in many cases

the underwear must also be taken into consideration. In many factories the underwear should have long sleeves and extend to the ankles. Where the skin hazard is a problem, the plant should furnish clean protective clothing to the worker. To insure this, they should be laundered by the plant, and issued to him daily. Aprons made of impervious materials should be worn and they should be of the proper length to give adequate protection. When rubber gloves are to be worn, they should be comfortable. Sometimes it may be necessary to have them lined with fabric to absorb perspiration. While natural rubber resists water-soluble irritants, synthetic rubber should be used when there is exposure to alkalis, petroleum distillates or the chlorohydrocarbon solvents. The glove open at the wrists or the gauntlet often increases the dermatitis hazard by allowing ingress of the irritant and thus producing increased exposure. It is imperative that impervious sleeves which fasten over the gloves and extend well above the elbows be used with the rubber gloves to prevent the entrance of irritants. They, too, should be made of impervious resistant material.

Because many workers object to the use of sleeves made of dark heavy materials, maintaining that they are too heating, Schwartz has suggested the use of synthetic resin films such as pliofilm and keroseal. They are impervious to dust, fumes, strong acids, alkalis and petroleum distillates, and are light in weight and because they are transparent give the impression of coolness.*

Especially in dusty operations leather gloves offer good protection and they are more comfortable to wear than the rubber gloves. They can be made of soft, washable leather, goatskin or chamois, and should have smooth seams so as not to irritate the skin.

Cleanliness

Under this heading, we have the most important single preventive measure. Adequate washing facilities should be provided. This includes not only hot and cold running water, but enough time, paid for by the plant, so that thorough washing is possible. There should be enough outlets so that workers do not have to wait beyond the time allowed and paid for. Where known industrial irritants are present, the showers should be supervised; the washroom should be so constructed that in order for the worker to replace his work clothes for street clothes he goes first to a set of lockers where he deposits his soiled clothing; goes into the shower and finally goes into another dressing room which contains his street clothes.

The proper type of cleanser must be available. Too often the industrial cleanser furnished for the workers acts as a skin irritant. Those workers exposed to solvents and who have dermatitis or dry skin should use special cleansers such as have been described by Schwartz.[5] These have been so formulated that the soil is quickly removed with the least amount of rubbing; are practically neutral and do not contain soap which may further injure the skin and they remove the least possible amount of the natural oils and fats from the skin.

Dermatitis can be prevented to a great extent if the irritants are quickly and thoroughly removed from the skin. In some instances where there is a great deal of exposure, the use of Bradley-type basins strategically placed in the shop where the worker can wash frequently enough without loss of much time may be necessary.

Protective Ointments

It has been repeatedly emphasized that protective ointments are not equal as protectives to protective clothing. However, the work must often be performed without gloves; moreover, workers prefer the protective ointments to other protective measures and may even refuse to use other measures. Often it is desirable to protect the face which cannot be safeguarded by protective clothing.

It should be emphasized that no single ointment can be made which gives protection against all irritants. Protective ointments of various types have been described:[1,5] The important thing to bear in mind is (1) know the irritant against which you wish to protect the worker and the mechanism by which the irritant produces dermatitis, (2) prescribe that ointment which is suitable, after a thorough investigation of the ointments on the market and their composition.

For example, to protect against a water-soluble irritant, the protective ointment itself must not be water soluble; to protect against a water-

*Such fabrics, now on priorities, will be obtainable after the war.

insoluble irritant, a protective ointment whose materials are soluble in water is desirable. When the mechanism of dermatitis production by the solvents is understood, we realize that to protect the worker against their action the oils and fats of the skin which are removed must be replaced. To do this, animal and vegetable oils contained in ointments are the best. In order that the workers properly use such an ointment, it should be made available to them on the production line, in a proper dispenser so that it can be used frequently and at the same time avoid contamination with the solvent as is so often seen where open jars are used. By means of lectures and pamphlets, the hazards of his job should be explained to the worker. He should be instructed in the various methods of protection. If for some reason it is not possible for the worker to be furnished with clean clothes and proper protective clothing by the plant then he should be instructed to do the next best thing and purchase them himself. The worker should be told why it is not possible for the plant management to put in the proper ventilation equipment or new showers, et cetera, because of the present difficulty of obtaining equipment. This is important in order to avoid a spirit of resentment in the worker which may not be justified and makes him less coöperative.

For many years, epidermophytosis has been the boogey man of the industrial physician. A great deal of emphasis has been placed on the role of epidermophytosis not only as a disabling dermatitis of its own in industry, but on the role that it might play as a predisposing factor in inducing hypersensitivity to industrial allergens. As you will recall, it was stated that dermatitis which is of the allergic contact type is much less frequent than that due to primary irritants, and in the group of allergic contact dermatitis itself, experience has shown that it has not been proven that the presence of an epidermophytosis has been responsible in a great measure for its occurrence.

Epidermophytosis among the industrial population is no greater than it is among the local population where the particular plant is situated, and it is still a debatable point whether fungus infections can be easily acquired from shower room floors. We are preparing a report on our studies concerning this question.[3] It can definitely be stated that fungus infections as a whole have not proven to be an important factor in causing lost time in industry. The fact that a worker has acquired a specific sensitivity to fungi does not mean that he is predisposed to sensitization to other allergens. However, the presence of open lesions in the skin no matter what the cause, removes a natural barrier and thus brings about more intimate contact between the living cells and the irritant and thus predisposes to dermatitis. Naturally, the presence of an epidermophytosis or an epidermophytid with active lesions such as vesicles, et cetera, serves as a portal of entry for industrial irritants.

Our studies have shown that epidermophytids on the hands of workers are of rare occurrence but it is only with epidermophytids of the hands that allergic contact dermatitis is likely to be confused. The present status of the problem being what it is, workers who must take showers should be protected against the possible acquisition of an epidermophytosis. The following prophylactic measures are recommended. To avoid contact between the worker and the shower room flooring, the best safeguard is to have him wear wooden-soled slippers which he uses in going to and from the showers. In addition, the shower room floors can be scrubbed frequently with antiseptic. As to foot baths which are so popular, it has been proven that the average worker does not stay in the foot bath a sufficient length of time for the solution therein to be more than theoretically effective. For this reason it is worth while to teach him prophylaxis. One of the most important steps which he can carry out is to make sure that he thoroughly dries between the toes. In addition, he can be given an antiseptic foot powder. Actual experiments have shown that an antiseptic foot powder is much more efficacious than just a drying foot powder which has no antiseptic value. He should be instructed to report to the first aid room if active lesions with vesicles, et cetera, appear.

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Criteria for Employability of Individuals with Lung Pathology

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■ In the days of peace, industrial physicians were fairly rigid in their conceptions as to physical and mental standards of acceptability for employment. Then the landslide hit us and we began to find that there were a lot more employable members of society than we had previously admitted. We have learned our lesson so well that we are beginning to ask each other, "Who isn't employable?" Or to put it a little more dramatically, one of my colleagues says that his pre-employment examination now consists in the visual determination that there is no faint suspicion of rigor mortis present! We physicians have been taught a lot by the war. The main text is that there are usually jobs which can be filled by those with physical, or with some mental, disabilities. What's necessary is an expert knowledge of each job requirement, a little imagination and a little patience on the part of the examining physician. He must know intimately the burden which the job applicant can safely bear, and the burden which the intended job will impose. If these burdens can be matched equally, the physician has accomplished his purpose.

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When we apply this concept to job applicants or working personnel suffering lung pathology we find that half of the task is easy and the other half extremely difficult. We can quickly determine the burden placed on these individuals by the physical requirements and environment of their job. Job analysis can reveal whether the work is ambulatory or sedentary, arduous or light. Dust counts, temperature and humidity readings, and gas analyses can inform us of the atmospheric safety. Thus, within a short time and with relative ease we can discover the exertion any job will require from any worker.

Our real stint begins when we try to gauge the size of the burden that lung pathology has placed upon the applicant or upon the worker. Here we must use the keenest clinical judgment of which we are capable, aided by whatever laboratory procedures can avail toward our decision. For we are deciding not only *whether* a person shall work, we are also deciding *where* he shall work.

Two guiding principles always influence our thoughts in the placement of pulmonary disabilities. First, is the lung process infectious? Can the affected individual harm others or aggravate his own disease at work? Second, has the process interfered with oxygenation of the body? To illustrate—one cannot allow a tuberculous person with positive sputum to continue work no matter how small his lesion—he constitutes a danger to others and to himself. Nor can a miner with a far advanced anthraco-silicosis continue his occupation. His dyspnea is too urgent, which is merely another way of saying that there is insufficient uninvolved lung tissue available to deliver an adequate oxygen supply to his working muscles.

Pulmonary disease fills several textbooks. It would be boring and unprofitable to survey with you all the ills human lungs fall heir to, then try to match a job to each disease. Rather, we will survey together the more common ailments that you and I are daily meeting in our work, with a view toward finding a rational method of handling the problems they present.

The pulmonary disease most often requiring a decision is nonindustrial. It is subacute bronchitis. When we apply our criteria to it we find that it contains both elements—first, it is infectious; it can be transmitted to others. Second, if

the coughing paroxysms are frequent enough, they certainly impede proper oxygenation. But there is another factor in the cough of subacute bronchitis. It is notoriously worse at night, so that even though the patient has relative comfort during the day, his nocturnal rest may be so disturbed as to make him a weary, careless or dangerous employe while at work.

How soon should we employ the worker recovering from an acute bronchitis? In order to be placed at work:

1. He must have a normal temperature;
2. He must be subject to not more than two coughing paroxysms nightly, and finally,
3. He must be placed in a working atmosphere where dust and fumes are either at a minimum or absent. He will not suffer from moderately hot atmospheres or relatively high humidity. In fact, such a physical environment may actually do him good.

While our minds are engaged with infectious respiratory diseases, a few thoughts on pneumonia will be apropos. Pneumonia, of course, poses no question of working during the disease. It also is the ideal illustration of a disease that is both highly infectious and seriously affects the oxygen supply to the body. Before 1935 no industrial physician in his right mind would allow a person to return to light sedentary work earlier than four weeks from the onset of pneumonia, and often it was six weeks to two months before full work could be resumed. Since the advent of the sulfonamide drugs, not infrequently the worker presents himself for work at the end of two weeks. He bears a note from his attending physician that he is completely well and able to resume work. Examination by the physician in industry only serves to corroborate the truth of these statements. He is put to work and even with careful check no ill effects can be noted. Our notions concerning the length of convalescence from pneumonia have necessarily undergone a sharp revision so that now no rule of thumb can be used. Each returning patient must be studied with a view to reëstablishing standard practices from a sufficiently large series. There is no more strenuous work than is required in training for the armed services, so that we may hope to use the pneumonia experience in training camp hospitals as a guide.

Currently there is a hot controversy over the possible predisposition of workers in certain trades to acquire pneumonia as an occupational disease. The question notably appears in industries where there is an exposure to silica dust. One gains the impression from the literature that the battle so far is a draw, for there is equally good clinical material to prove the case for either side. It is always dangerous to deduce human analogies from animal experiments; yet there is one report of dusting the lungs of rats that seems significant. Baetjer and Vintinner of Johns Hopkins have now a paper in publication on "The Effect of Silica and Feldspar Dusts on Susceptibility to Lobar Pneumonia." Their work may be summarized as follows:

The lungs of rats were dusted with silica and feldspar for periods varying from one to 157 days before inoculation, each day representing eight hours of dusting. The rats were then inoculated intratracheally with a suspension of pneumococcus Type I in gastric mucin or with a broth culture of the same type of pneumococcus. The animals were then autopsied, either after natural death or after a certain predetermined experimental period. An equal control group was set up without the dusting.

It was found that:

1. It was far easier to induce lobar pneumonia in rats with a small number of pneumococci suspended in gastric mucin than if the pneumococci were suspended in broth.
2. The controls in both groups showed a much higher incidence of lobar pneumonia than the dusted animals, from which it was logical to conclude that the inhalation of silica and feldspar dusts actually protected the lungs of these animals from lobar pneumonia.

The authors wisely conclude, "What analogy there may be between this and human lobar pneumonia can only be deduced."

At present, because of draft requirements, most industrial physicians are being forcefully presented with many of the problems of geriatrics. Certainly our civilian male population available for work is embraced in the group aged 45 years or more. One of the commonest, least frequently mentioned, diseases of advancing age is pulmonary emphysema. It has no infectious quality but it is one of the most potent forces known in cutting down the proper supply of oxygen to the body tissues. In fact, one of the most fascinating medical studies I ever made

was on a patient in my intern days who had an erythrocytosis based entirely on pronounced emphysema. But from the industrial point of view, my friend Cosimo is an excellent illustration of the handicap this disease may impose upon a worker. Cosimo was born in Italy seventy-eight years ago and today works his full shift. He has worked sixty-five years in tobacco. His duties are all on the same level, for if he climbed a flight of steps he would be forced to sit on the top one to regain his breath. He lifts nothing heavier than a hand of tobacco; yet because of his long experience he is exceedingly valuable in the processing of tobacco. His chest is barrel-shaped and he has the dorso-cervical kyphosis characteristic of advanced emphysema. He stands most of the day at his job despite a complete right inguinal hernia, but there is a chair handy which he uses as he desires. Cosimo is the marvel of our workers because of his unfailing daily appearance at work despite his advanced age. He and I both know the secret. He has adjusted himself perfectly to his emphysema and does not overtax his strength in extraneous effort. One could wish that every handicapped person might quickly learn such common sense!

From the employment standpoint, pulmonary tuberculosis can be divided into two types—industrial and nonindustrial. Basically there is only one cause for the disease, the tubercle bacillus. But industrially we must pay attention to the individual who has acquired this infection because he has underlying pathology that has been induced by work. In all fairness we must then admit he was predisposed to his tuberculosis by his work. The greatest single industrial precursor of pulmonary tuberculosis is silicosis. Sufficient has now been written on the relationship between these two diseases to leave no doubt that the one often precedes the other. The tuberculo-silicotic group is the only one that has set pulmonary tuberculosis off as a definite occupational disease in the compensation practice of many states in the Union.

The great problem of tuberculosis is its inherent power to cause sickness absenteeism or death among the working population. It is an infectious disease. It can involve large areas of lung tissue before its victim is aware of trouble, and in this latent period he may infect others. Therefore, the industrial physician must approach the examination of every worker's lungs with his index of suspicion registering 100 per cent. Only after the physician has proved that there are no symptoms, there are no clinical signs, and the chest x-ray is negative, can he honestly diagnose freedom from tuberculosis. In average urban populations the tuberculosis incidence runs constantly 290 to 300 per 10,000. This figure includes both active and arrested cases. It warns us that three out of every 100 people come for employment bringing their pulmonary tuberculosis with them, and it is up to us to devise techniques so that their tuberculosis may be properly evaluated and as many as possible allowed to work. Because the ninety-seven are not infected we must not be lulled into a statistical smugness which makes us slovenly in the discovery of the affected three. In my own medical department at Bayuk Cigars Incorporated we have slowly devised a satisfactory system for the discovery and management of unsuspected pulmonary afflictions. At the preemployment examination, after a routine clinical physical examination, we fluoroscope the lungs of every applicant. The results have been so informative, and reveal so much that the stethoscope failed to divulge, that I believe the stethoscope is now an obsolete instrument for the diagnosis of tuberculosis when we wish to find it, i.e., when the patient is apparently well. If, fluoroscopically, the job applicant's lungs show shadows that require further study, he is immediately referred to the Henry Phipps Institute for the Study of Tuberculosis, where 14- by 17-inch radiographs are made. If those radiographs show arrested lesions, the applicant is given a suitable job—but we try to follow him fluoroscopically every six months to keep his process under control. The same technique is followed in our periodic health examinations, except that in this instance the company pays for the extra examination. Thus we have built up a group of employes who are kept under observation constantly, yet are proving to be valuable workers. We will not allow anyone with the diagnosis of adult tuberculosis to be placed in a job requiring heavy lifting or inordinately long hours; otherwise they are on an employment par with all our other employes.

The pneumokonioses have been neglected thus far in this paper for two reasons. First, only 1,000,000 of America's 60,000,000 workers are ever exposed, and, of that million, not more than

400,000 at most are ever exposed to a significant dust concentration. Second, because *disability* due to these diseases is compensable in money, they have assumed an importance which they do not deserve if measured on the basis of total man-days lost to the nation. We are in a period of great doubt concerning employment practices when dealing with silicotics or anthraco-silicotics. The question of *the degree of disability* is now mainly answered on the basis of what the worker thinks he can do without dyspnea, or on what the medical man observes he can do without dyspnea. We are still waiting for a simple test which will inform us reliably with the answer to that question. All of us have seen radiographs of lungs almost completely silicotic; yet the worker continues at his employment without much pulmonary embarrassment. *Per contra,* we have seen silicotics completely prostrated by only a small fibrotic dispersion in the lungs. Certainly, no industrial medical decision requires more individualization at present than determining the disability of a silicotic person.

Finally, no one can long practice routine roentgen examination of workers' lungs without developing a group of problem children. The list will include sarcoid, cysts, local atelectases, spontaneous or therapeutic pneumothoraces, neoplasms, abscesses, and on rare occasions a lues of the lung. In each instance they can only be dealt with individually from the employment standpoint.

Summary

In summary, I should like to stress several points as the gist of what I have tried to convey to you.

1. X-ray of the lung should be used routinely in addition to the usual clinical and other laboratory examinations in evaluating the proper job for an applicant or worker.

2. If pulmonary pathology be discovered, the physician must balance the burden of the job against the burden of the pathology. This can only be done if he knows intimately the job requirements and if he can satisfy himself that the pathology is not infectious nor capable of too seriously interfering with proper oxygenation of the worker's body tissues.

Reconditioning Problems for Disabled Veterans

By Marion W. Jocz, M.D.
and
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Detroit, Michigan



M. W. Jocz

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■ The present war has provided industry with experience in the rehabilitation of handicapped workers before the first handicapped veteran returned to work. In order to replace the millions of physically qualified men who have gone into service, some people have, in the past two years, been forced to look to the previously untapped reservoirs of handicapped and substandard workers. Large numbers of blind, one-armed and one-legged individuals have been hired. Even larger numbers with cardiac or pulmonary impairments, emotional and personality defects have been employed. Many have been handicapped not only physically, but also by lack of skill.

From the experience thus gained, some have developed programs for the systematic and selective placement of handicapped workers. In a sense, the handicapped civilian has shown the way for the employment of the handicapped veteran.

Since Pearl Harbor, the military has discharged almost fifty thousand men in Michigan alone. Most of those discharged have not been overseas but have been disqualified while still in training. The great majority of battle casualties, the severely disabled, the severely ill, and the major psychiatric cases are still in hospitals. Few amputations have been released; the others are being taught new trades in government hospitals.

Most of the returned soldiers have been placed at work with little difficulty. The handicaps which have unsuited them for the army have

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been relatively minor: over-age, "couldn't eat army food," "couldn't march," "dizzy spells," "heart pounding," "nervousness," et cetera. Some feel stigmatized, others overcompensate by parading a manufactured heroism. Some have presented major job-placement problems.

The problem of re-integrating and reconditioning handicapped servicemen in industry is logically of two parts. The first concerns their proper functional placement as to job and environment; the second, the physio- and the psychotherapy necessary, subsequent to employment, to solidly adjust the handicapped to peacetime vocations. For expediency, I will refer to these phases of the program as preplacement and postplacement reconditioning.

Preplacement

Considering the first of these parts, proper functional placement, it is apparent that selective preplacement examinations must be designed to install handicapped individuals on jobs which are physically, as well as mentally, within their functional capacity.

Essentially programs for this purpose require each returning serviceman be cordially but not effusively welcomed upon his return to work by a qualified individual exclusively assigned to this duty. In many cases this individual may be the plant personnel manager himself. Here his employment requests should be received, his skill evaluated, and special factors apart from his health discussed. Following this initial contact the applicant may be sent to the medical department for examination.

The medical department might classify each individual, depending upon his examination results, into one of three general classifications: (1) **PQ**, physically qualified for any job, (2) **NPQ**, not physically qualified for any job, (3) **PQX**, physically qualified for jobs not harmful to the individual's disabilities.

For the purpose of conducting such a physical examination program, the medical department may set up physical examination standards to conform with these three classifications.

For individuals classified in the third group, the **PQX**, or conditionally qualified applicants, a code might be established which defines the individual's disabilities in functional terms. One code developed for this purpose is comprised of two parts—code letters which define broadly the individual's capacity to do heavy, moderately heavy, light, or very light labor; and a series of modification code numbers for the interpretation of specific disabilities (Table I).

An important feature of a coding procedure is that no specific medical diagnosis need be communicated to anyone beyond the medical department. The medical record can be maintained in a confidential medical department file. No information, apart from classification symbols and code numerals, need be transmitted to any other person or agency.

Under such a plan, the physician is not informed as to what type of job the applicant is scheduled to do. He is not examining the man for one particular job but for a group of jobs which that man might fill. It is not necessary for the physician to match each individual machine against all the diseases in Medicine and then decide that Machine Number One Thousand can take a TB, a nephritic, or a cataract, but not an ankylosed wrist or a poker spine. The common denominator in deciding what job the applicant can handle is Functional Capacity.

Under such a procedure the plant physician may determine the absence of or the limitation of the capacity of an indivdual for standing, sitting, walking, climbing, lifting, stooping, and so forth, and not specifically whether he can drive a jitney, or lift an axle, or lower a ton of steel from a crane into a bin fifty feet below. In other words, the physician can simply describe the functional periphery of the applicant.

When the applicant is returned to the personnel department in company with his functional code classification, the latter agency may proceed to place him in accordance with his skill and desires, subject to the limitations of his coding and job availability.

The matching process may be expedited by job surveys which define each job within a plant in terms of specific physical requirements and the functional capacity required in its performance. Here again the disability code may be utilized. The job survey can be expressed in the same symbols as are used for the physical examination coding, but with opposite meaning. Thus, when the applicant's coding is compared with the codings of jobs available, the presence of a letter or number in the job code which also appears in the physical examination code may disqualify the applicant from that particular job.

TABLE I. PQX—PLACEMENT CODE

A. Heavy sustained labor. B. Moderately heavy labor. C. Light labor. D. Very light labor.

Modification

1. New hire (except service personnel) is NPQ

General Functions

10. No standing.
11. Standing less than 50% of the time.
12. Standing more than 50% but not all of the time.

20. No sitting.
21. Sitting less than 50% of the time.
22. Sitting more than 50% but not all of the time.

30. No walking.
31. Walking less than 50% of the time.
32. Walking more than 50% but not all of the time.

40. No climbing.
41. Climbing less than 50% of the time.
42. Climbing more than 50% but not all of the time.

50. No lifting or carrying.
51. Moderate or less than moderate lifting or carrying.
52. No pushing or pulling.
53. Moderate or less than moderate pushing or pulling.

60. No stooping.
61. Stooping less than 50% of the time.
62. Stooping more than 50% but not all of the time.

Special Senses

70. No near vision.
71. Some but not good near vision.
73. Some but not good distance vision.
74. No binocular vision.
75. Some but not good binocular vision.
76. No color perception.
77. Has vision in one eye only.

2. Hernia statement advised.

80. No hearing.
81. Some but not good hearing.

Specific Functions

90. No use of right hand or arm.
91. Partial use of right hand or arm.

100. No use of left hand or arm.
101. Partial use of left hand or arm.

110. No use of right foot or leg.
111. Partial use of right foot or leg.

120. No use of left foot or leg.
121. Partial use of left foot or leg.

130. Physical reactions not prompt.
135. No speech.

Environment

140. No danger from dizziness, fainting, or convulsions.

141. Nervous disorder (specify environmental limitations).
150. No exposure to dusts, smokes, fumes, vapors, gases, and mists.
151. No exposure to excessive noise.
152. No exposure to excessive heat.
153. No exposure to excessive cold.

160. No exposure to any skin irritants (particularly no wet jobs).
161. No exposure to specific skin irritants (specify).

170. Certain shift recommended (specify).

Such a procedure of coding both jobs and applicants can simplify the placing of disabled individuals into an almost automatic matching operation.

The "not physically qualified" classification previously mentioned can be reduced to minimum proportions. Its purpose should be to provide a floor or screen which will bar from employment only those individuals with actively communicable and contagious diseases or disabilities of such extreme degree that they can perform no function, or who are so severely disabled as to jeopardize their own life and those of their fellow workers in even the safest work environments.

Once a selected placement has been made, it must be followed. This responsibility, in the usual industrial organization, falls to the safety division. This agency should be provided with a copy of the applicant's code classification and periodically should check the job and the individual to see that his coding is in no way violated and that no undue difficulty is experienced. No job transfers should be permitted without the certification by the safety division that the new job does not violate the employe's code classification.

In addition to his safety follow-up, medical departments may request, and in some cases routinely request, that disabled employes report periodically to the medical department for a review of progress.

Postplacement

The second part of an industrial reconditioning program—the postplacement program—should begin where the first part stops.

Even with a selective placement program there is a compelling necessity to further minimize worker disabilities. The reasons for such action touch upon many facets of the general problem of reconditioning and would be too numerous to include here. Significant among them, however, are the necessity for improving morale by widening the field of personal opportunity, improving efficiency, and removing, as much as possible, the awareness of disability.

The proportion of cases to be handled under

a postplacement program will, of necessity, be only a fraction of the disabled group who are returned to work. By definition, however, they will involve the more difficult problems of re-

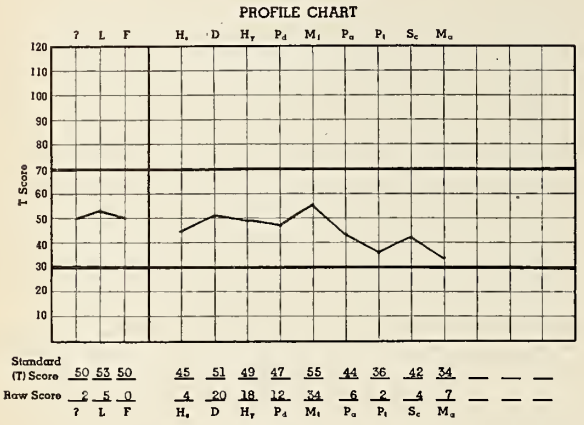


Fig. 1.

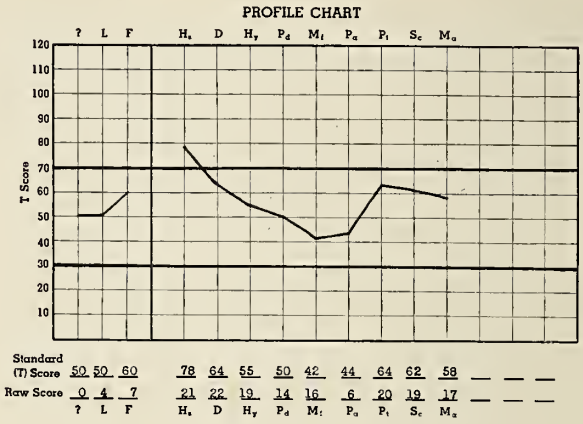


Fig. 2.

conditioning. It is expected that in many cases the problem will be a complex of variables involving both physiotherapy and psychotherapy.

For the most part, it may be assumed that the more serious cases, both mental and physical, will have achieved a great part of their recovery in government institutions. But there will be many of these cases which will be recurrent in nature and which will require intermittent and continuing treatment.

It is not possible nor feasible to outline a rigid program of postplacement reconditioning. Some of the disabled servicemen who enter industry will require periodic treatment which can best be handled by visits to government medical agencies. Some will require treatment from both industry and governmental agencies. Some can be handled by industry alone.

It would seem that the best postplacement reconditioning program might be that which provides for both governmental and industrial medcal participation. Thus, for example, some industries might well find it necessary and profitable to extend their physiotherapy facilities to include the more complex procedures in hydrotherapy, massage, exercise, and so forth. Similarly with psychotherapy, to provide for personality analyses and correction, on at least a minimum scale. Cases which become nonambulatory or require hospitalization, together with those requiring more extended treatment, might be referred back to government medical agencies.

As previously indicated, the mental and emo-

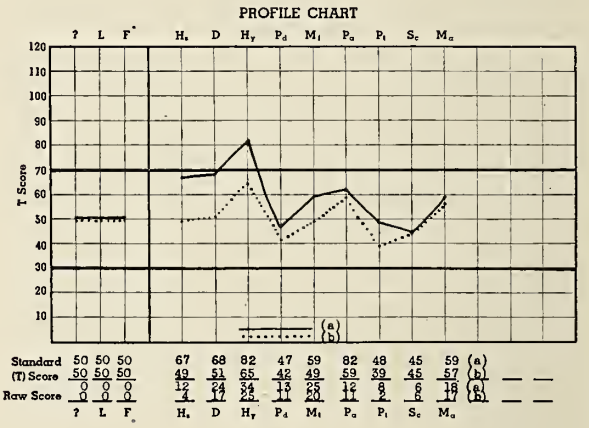


Fig. 3.

tional problems in rehabilitation are most vital. If once having satisfactorily adapted physical handicaps to a work environment, there yet remains the problem of mental compatibility. The appraisal of significant mental handicaps, especially those well hidden beneath the surface, is extremely difficult for physicians with no training in psychiatry. A test has been devised which is designed to rapidly and systematically detect abnormal personality traits and indicates whether the subject should have further evaluation by a trained psychiatrist.

The test is called the Minnesota Multiphasic Personality Inventory. It was developed by Dr. Starke R. Hathaway and Dr. J. Charnley McKinley* of the University of Minnesota Medical

*J. C. McKinley and S. R. Hathaway: The identification and measurement of the psychoneuroses in medical practice: The Minnesota multiphasic personality inventory. J.A.M.A., 122: 161-167, 1943.

School. It is the result of five years of study by the authors.

The test consists of 550 statements, each printed on a separate card, and is self-administered. The statements refer to the subject's general body health, his habits, his occupational, religious, social, and sexual attitudes; his family and marital relationships, his moods, morale, phobias, obsessions, compulsions, delusions, hallucinations, and so forth. The subject is given the cards and asked to sort them into three groups—True, False, and Cannot Say. Answers usually given by normal people are not used. Only the significant answers are recorded on a record blank. Transparent templates are used for obtaining the various scores. These scores are plotted on a graph and a curve or "profile" obtained. The work can be done by a clerk, but the "profile" is interpreted by a physician.

Scores between 30 and 70 are interpreted as being within "normal" limits, although scores between 60 and 70 are given "borderline" significance. Scores above 70 are considered abnormal and indicate the need for further clinical psychiatric appraisal. In our estimation such a test should not take the place of a personal interview by a psychiatrist but may be a valuable aid in detecting those people in need of such interviews. The test, at present, shows the strengths of the following personality traits in the individual: hypochondriasis (Hs); depression (D); hysteria (Hy); psychopathic personality (Pd); masculinity-femininity interests (Mf); paranoia (Pa); psychasthenia (Pt); schizophrenia (Sc); and hypomania (Ma).

Lack of space does not permit the illustration of profiles showing each of these personality traits singly and in combination. A detailed study of the usefulness of this test as a filter will be presented at a later date. For purposes of brief illustration, Figure 1 represents a "normal" profile; Figure 2 represents a profile significant of hypochondriasis, and Figure 3 a profile significant of hysteria. In Figure 3, the solid line was obtained when the subject was incapacitated from work by conversion hysteria, while the broken line was obtained after four weeks' rest with marked clinical improvement.

In conclusion, we should like to leave this thought: That the problem of reconditioning in its broadest aspect is, after all, of enormous scope and will not be solved unless all concerned are equipped and prepared to meet it.

Ocular Pathology Due to Organic Compounds

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■ THE chemical industry is more and more concerned with the protection of its employes in the hazardous occupations in its own plants where useful chemicals are produced; secondly, with the safeguarding of those workers in other industries who use these chemicals to achieve their products; and thirdly, providing the individual in his home with information to enable him to ultimately use all these products. This latter case is emphasized again in the case of naphthalene which is widely employed in industry, agriculture, and the home. Yet, it is in the home that most all of the naphthalene poisonings occur. Think, for a moment, on how really widespread is the use of chemicals as refrigerants, as medicine, dry cleaners, paint solvents, insecticides, fire extinguishers, rubber vulcanization, plating solutions, leather working, plasticizers, degreasers, garden and orchard sprays and dusts, war gases, and so on. The need for the protection against chemical hazards and the urgency for widespread information in the handling of the chemicals is very great.

The occurrence of cataracts, optic atrophy, retrobulbar neuritis, and other ocular disturbances has given impetus to our interest in this field of study. The frequency of ocular injuries is about 25 per cent and the cost to industry about 50 per cent of all the injuries coming to first aid. The immensity of this problem requires a physician, a safety engineer, and chemist to prevent and to control chemical injuries. Many protec-

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tive techniques peculiar to the chemical industry are in operation to control toxic materials, gases, dusts, sprays, and vapors; to shield against flying objects and radiant energy; and to provide the worker with adequate and suitable illumination.

Research in biochemistry is a companion protective measure of immeasurable value. Study of the physiological and the pathological changes in experimental animals employing chemically pure organic compounds is creating a storehouse of highly useful information. The knowledge of the physiological behavior of the two great classes of organic compounds, alipathic and aromatic, is broadened with each new investigation. We wish to turn your attention toward some of the ring-type or aromatic compounds having common bondage by the parent benzene ring.

Some of these organic compounds can do an astonishing amount of damage to the human and to the experimental animal. Benzene produces a well-marked aplastic anemia; closely allied chemical relatives such as toluene have been blamed for similar action, but there is evidence to the contrary. Almost without exception, poisonings of this type are due to benzene itself. B-Naphthylamine has been shown to be the causative agent of many of the so-called "aniline tumors" of the urinary bladder which have been encountered in the dye industry. Dinitrophenol is a metabolic stimulant which was brought to the attention of the medical world in 1933 by Prof. C. Heymans of Ghent who advocated its use for the relief of obesity and of states of hypothyroidism. Clinically, this drug is charged with causing cataracts in one per cent or less of the people who have taken it. In a report by Tainter, Bergstrom, and Cutting from the departments of pharmacology, chemistry, and medicine of Stanford University a review of the activity or lack of activity of dinitrophenol and fifty related compounds was thoroughly covered. In general, their work showed that only the creosols and the dinitrophenols were active metabolically in rats, pigeons, and dogs. In 1939 Berliner published an article in which he described two clinical cases with cataracts which he asserted were due to prolonged exposure to a "deodorant" or "mothproofer" containing para-dichloro-benzene. He also produced cataracts in one rabbit supposedly by the combination of oral feedings of para-dichlorobenzene and exposure to its vapors. His experimental work consisted of four rabbits kept in specially constructed cages with variable amounts of ventilation and para-dichlorobenzene vapor. No indication is given as to the source or purity of the para-dichlorobenzene used in this experimental work.

We have been interested in the toxicity of para-dichlorobenzene for some years now. Our clinical experience of the effects of this chemical compound in man is considerable in comparison with that of other medical men. Some workmen have had considerable exposure to it in the form of spray. None have ever complained of visual disturbance at any time attributable to this substance. One man afflicted with congenital cataracts was allowed to work in this field and showed no new ocular changes. None of the workmen ever had a papillitis or retrobulbar neuritis.

In our experimental work we desired particularly to have as pure a chemical compound as could be obtained.

PARA-DICHLOROBENZENE

Source: The Dow Chemical Company
Boiling range: 172.5 to 173.6 C.
(from first drop to dry point)
Freezing point: 53.0 C.
Per cent chlorine: 48.27 (theoretical is 48.24)
Specific gravity: 60/60 C.: 1.2632

Several rabbits were given repeated eight-hour exposures to para-dichlorobenzene vapors at a concentration of 4.6 to 4.8 mg./1. or 770 to 800 parts per million. This concentration of para-dichlorobenzene is from five to ten times the concentration that the average man will voluntarily tolerate.

It is evident that repeated exposures to such a concentration of p-dichlorobenzene vapor produced such a marked intoxication that some animals died after a few exposures, while only a few withstood as many as sixty-two repeated eight-hour exposures. All of the exposed animals showed marked tremors and weakness but no actual paralysis. Lateral nystagmus was observed in several of the animals while at least two of them showed transitory edema of the cornea. All of the rabbits showed edema of the optic nerve head which was progressive to a point of three to five diopters in amount. The physiological cup was obliterated and the margins of the nerve heads melted into the neigh-

boring retinal edema. The veins early became congested and their enlargement grew in intensity with the increase in edema of the optic nerve. The arteries were relatively smaller in calibre. Often venous pulsations were quite marked in the retinal veins. No hemorrhages or exudates appeared in any animal eye. Three of these rabbits survived sixty-two eight-hour exposures to the vapor over a period of eighty-three days; two of these three were allowed to recover. Within seventeen days the nerve heads were restored to nearly normal elevation although the margins were sharper and the color of the disc paler. The physiological cup reappeared and, in some rabbits, seemed larger than normal. The vessels regained a normal ratio of size. No disturbance of the retina was visible. The media of all eyes was clear. The animals were free of tremors and began a normal weight gain once more.

The eye changes observed in these rabbits were reversible in nature and were of the type commonly associated with acute intoxications. They cannot be considered as specific for para-dichlorobenzene. In no case were lens changes or deposits in the vitreous observed. We take this opportunity to describe these changes since they are not subject to photographic demonstration. The surviving animals behaved as if there were no disturbance in their vision.

An attempt was made in this experimental work to give rabbits repeated oral doses of para-dichlorobenzene at high enough dosage levels to produce definite intoxication, but still low enough to allow most of the animals to survive for a considerable period of time. Since it has been shown by several investigators that orally administered naphthalene produces cataracts in rabbits, this compound also was fed to a parallel group of rabbits in order to demonstrate that the cataracts could be produced in our strain of rabbits by chemical means. In these experiments we were particularly interested in the lens of the eye and the changes which occur in it as the result of the administration of a pure chemical compound. The lens of the eye among mammals is more alike in behavior and chemical composition than any other tissue of the body. Serologically the lens proteins give organ specific and species indifferent reactions. Furthermore, the eye lends itself to photographic recording of the cataract changes exceedingly well and is open to daily inspection with the ophthalmoscope and slit-lamp until the lens changes are too dense to see through.

Repeated oral doses of para-dichlorobenzene at the levels of 0.5 and 1.0 g./kg. were administered to the rabbits by means of a stomach tube five days a week. This dosage is equivalent to 35 to 70 grams for an average-sized man.

It was found that repeated doses of 1.0 g./kg. produced marked intoxication, weakness, tremors, loss of weight, and even death. Repeated doses of 0.5 g./kg. were tolerated for long periods of time, even up to one year. However, such quantities of p-dichlorobenzene produced definite tremors and the other signs of intoxication. The eye changes which were observed in the rabbits exposed to high concentrations of p-dichlorobenzene vapor were not found in these rabbits receiving repeated oral doses of p-dichlorobenzene. In none of these rabbits were there any lens changes or deposits in the vitreous, regardless of the size of the oral dose or the amount received by inhaling the vapor.

On the other hand, cataracts were readily produced in the rabbits receiving naphthalene orally.

NAPHTHALENE (resublimed)

Source: Merck Chemical Co.
Boiling range: 215.9-218.4 C. From first drop to dryness. (Theoretical 217.9)
Freezing point: 79.9 C.
Specific gravity: (?)
Melting point: 79.3, meniscus 80.1 C.; fluid 81.4 C. (Theoretical 80.2 C.)

These rabbits were given repeated oral doses of naphthalene at the dosage levels of 0.5 and 1.0 g./kg. which were sufficient to produce loss of weight and definite signs of intoxication. The lens changes appeared quite rapidly in the colored rabbits and somewhat more slowly in the white-haired rabbits. Some of the rabbits were observed for several months after discontinuing the administration of naphthalene in order to follow the changes occurring upon absorption of the cataract.

Three typical growth curves show that sufficient p-dichlorobenzene and naphthalene were being administered in repeated oral doses to produce a definite effect upon the body weight of the rabbit. This effect upon growth was only one of the manifestations of marked intoxication produced by the dosages given. It should

be emphasized that in spite of the repeated oral administration of such quantities of p-dichlorobenzene none of the rabbits receiving the material developed any lens changes whatsoever.

Berliner suggests that disturbances arising from hepatic damage may play a role in the formation of cataract. However, examination of the livers from several of the rabbits that had received repeated doses of either para-dichlorobenzene or of naphthalene for periods as long as one year revealed no pronounced pathological changes. Hepatic damage surely cannot account for the rapid onset of cataract observed in the rabbits receiving naphthalene. Furthermore, cataracts are not associated with intoxications resulting from known hepato-toxic agents such as chloroform, carbon tetrachloride, or phosphorus.

We were unable to produce any lens changes in either rats or guinea pigs by repeated exposures to the vapor of para-dichlorobenzene or by repeated oral doses of either naphthalene or para-dichlorobenzene.

In the course of the experimental work a great many movies were taken of these animals, and particularly of their eyes. These serve as a permanent record of the actual condition of the eye and the changes that occurred during the course of the experiment.

In the case of the rabbits receiving naphthalene the status of the toxic lens changes can be seen from early to late in a most dramatic fashion. In distinct contrast to these spectacular changes produced by naphthalene, no changes were demonstrable in the lenses of the rabbits receiving para-dichlorobenzene for periods as long as one year.

Summary

1. Cataracts were produced in rabbits by the oral administration of naphthalene. The progressive pathological lens changes have been recorded by means of color photography.

2. While repeated exposures of rabbits to very high concentrations (4.6 to 4.8 mg./1.) of para-dichlorobenzene vapor produced definite intoxication, including tremors and toxic eye ground changes, no lens changes were observed.

3. Prolonged oral administration of definitely toxic quantities of para-dichlorobenzene to rabbits did not produce any lens changes whatever.

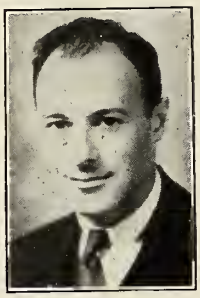
Conclusion

Our clinical experience, together with the evidence gained from experimetnal work with animals, has led us to believe that cataracts are not produced by para-dichlorobenzene either by oral ingestion or inhalation of its vapors in either man or rabbit.

MSMS

Penicillin in Surgery

John Winslow Hirshfeld, M.D.
Detroit, Michigan



Assistant Professor of Surgery, Wayne University College of Medicine.

■ SOMETIMES men have in their possession a priceless substance that they do not appreciate. Other times men value a substance far beyond its true worth. Penicillin has found itself in both situations. When Fleming discovered it in 1929, he did not realize how important it would become. On the other hand, penicillin does not have the extraordinary powers that some people are inclined to attribute to it.

The information that we have concerning the value of penicillin in certain infections has been gathered in the brief space of a few years. Although penicillin was discovered in 1929,[7] it was not employed clinically until 1941, when a group of English workers[1] reported the results of penicillin therapy in ten patients. Furthermore, until comparatively recently the supply of penicillin was so meager that it was possible to treat only a few patients with it; our experience, therefore, is not large. In spite of this, there is sufficient evidence to justify the conclusion that penicillin is a substance of great value. One has only to witness the recovery of a few moribund

Presented at the Second Annual Postgraduate Industrial Medical and Surgical Conference, sponsored by the Committee on Industrial Health of the Michigan State Medical Society, at Detroit, April 6, 1944.

patients to realize that while at timees this drug may fail, it is often capable of performing what a few years ago would have been termed miracles.

Penicillin is important not only because of its own properties but because it heralds a new era in our battle with the pathogenic bacteria. Penicillin is not effective against all bacteria; many pathogenic bacteria are completely immune to it. The success of penicillin, however, has encouraged bacteriologists to search for other substances elaborated by microörganisms, other antibiotics that are nontoxic for men and yet effective against the pathogenic bacteria that penicillin does not harm. Already many compounds have been isolated and tested. Some appear promising. It is well within the realm of possibility that within the next decade substances will be available that will revolutionize the treatment of bacterial infections.

The history of penicillin is exceedingly interesting. In 1929[6,7] Fleming noted the unusual appearance of a petri plate culture of *Staphylococcus aureus* that had beecome contaminated by a mold. The colonies of staphylococci near the mold "appeared to be fading away." Instead of throwing away the contaminated culture, he puzzled over the failure of the staphylococci to grow near the mold. This questioning led to a series of experiments in which he showed that the mold liberated a substance highly toxic for certain bacteria and completely innocuous for others. Fleming demonstrated that the mold could be grown in broth; that the filtrate contained the active substance; and that the substance was nontoxic for animals. He suggested that it might be used for injection into areas or application on areas infected with penicillin-sensitive microbes. He also tried it on a few superficial skin infections in man, but he gives very little information about this.

In 1932, Clutterbuck, Lovell, and Raistrick[3] attempted to identify the substance chemically. From this time until 1939, very little was done with penicillin. Sporadic reports of work appeared, but nothing of note was accomplished until Florey, in 1939, organized a team of research workers at Oxford to investigate penicillin systematically. In 1940[2] Florey *et al* reported some very promising animal protective experiments, and in 1941[1] they were able to employ penicillin in the treatment of ten patients. These papers stimulated interest in this country, and in the fall of 1941 arrangements were made for the production of penicillin in the United States. Since this time progress has been rapid, both in the production and purification of penicillin and in its employment for the treatment of infections.

The exact chemical structure of penicillin is not known. It is certain that it is not a protein. It is an acid, however, and is usually prepared in the form of its salts. Inasmuch as its chemical structure is not known, the drug must be standardized biologically—in terms of its power to prevent the growth of bacteria. The unit in common use is the Oxford unit. By definition an Oxford unit is that amount of penicillin which, when dissolved in 50 c.c. of meat extract broth, will just suffice to inhibit completely the growth of a test strain of *Staphylococcus aureus*. It is an exceedingly powerful antibacterial substance. Cook[4] in 1942 reported the preparation of a product with an activity of 750 Oxford units per milligram. Florey[6] has reported the preparation of penicillin that will prevent the growth of staphylococci and streptococci at dilutions between 1:50,000,000 and 1:100,000,000 and will produce morphological changes at dilutions of 1:-256,000,000.

It is important to realize that penicillin is effective only against certain organisms. This was emphasized by Fleming in his original papers[7,8] and again by Hobby, Meyer, and Chaffee.[9] The latter authors tested many organisms in vitro against penicillin. They found that the susceptible group includes: *pneumococcus, Streptococcus hemolyticus, Staphylococcus albus* (some strains), *Staphylococcus aureus, meningococcus, Streptococcus viridans, B. subtilis, Cl. welchii, V. septique, Cl. histolyticum, B. sporogenes, B. oedematiens, B. sordelli, Lactobacillus, Cryptococcus hominis.* The unsusceptible group includes: *H. inflenzae, E. coli, B. typhosum, B. dysenteriae, B. proteus, B. paratyphosum, B. enteritidis, B. pyocyaneus, B. fluorescens, B. prodigiosus, Friedländer's bacillus, Staphylococcus albus* (some strains), *Monilia albicans, Monilia krusei, Monilia candida.* It is apparent that there are many surgical infections that penicillin cannot be expected to benefit, since the causative organisms are not susceptible to its action.

Penicillin acts mainly by bacteriostasis; however, under certain circumstances it will kill bacteria. This action is not immediate but requires

several hours. Unlike the sulfonamides, the action of penicillin is not hindered by pus, tissue autolysates, or para-amino-benzoic acid. In fact, penicillin is effective when injected into an abscess. Also in contrast to the sulfonamides, penicillin is effective against large numbers of bacteria.

The toxicity of penicillin for man is not definitely known. The following reactions have been encountered in cases treated with penicillin:[10,11]

1. Chills with or without fever after intravenous injection
2. Eosinophilia of 20 to 30 per cent
3. Burning pain at site of intramuscular injection
4. Headache
5. Faintness and flushing of the face
6. Unpleasant taste after parenteral injection
7. Tingling in the testes
8. Muscular cramps
9. Femoral phlebothrombosis

Most of these reactions occurred during the developmental period of penicillin therapy and were attributed to impurities. With improvement in the purity of the product, toxic episodes have steadily decreased. Those which still occur are:

1. Urticaria with or without fever occasionally associated with abdominal cramps and pain in the joints
2. Fever during first five days of therapy
3. Transient azotemia
4. Thrombophlebitis at site of intravenous injection

None of these manifestations is severe enough to require cessation of therapy.

Penicillin is supplied at present in the form of its sodium or calcium salt. These come in sealed ampules which must be stored at or below 5° C. There is some question about the necessity for keeping this material cold, but until this has been settled, refrigeration is the safer course. The salts are extremely soluble and can be dissolved in distilled water, isotonic saline, or 5 per cent glucose solution. Once in solution, they tend to deteriorate and must be kept cold and must be used within 24-48 hours. The sodium and calcium salts of penicillin are so soluble that one can make almost any desired concentration per c.c.

The theoretical object of treatment is to maintain a *sufficient* concentration of penicillin *constantly* in contact with the infecting bacteria so as to inhibit completely the growth of the bacteria. There is, however, some evidence to show that this may not be necessary.[12,15] Patients seem to recover from infections in spite of the fact that the concentration of penicillin in the blood has never been sufficient to inhibit completely the growth of the organisms or has been only intermittently sufficient. Penicillin should be present in all the body fluids to combat such generalized infections as staphylococcal infection with bacteremia in which there may be not only invasion of the blood stream but also multiple scattered abscesses. In local infections, such as empyema, a high concentration of the drug must be present in and about the abscess.

In order to effect the optimum concentration of penicillin for a given infection, one must know three things: (1) the concentration of penicillin required to inhibit the growth of the offending organism, (2) the routes by which the drug may be administered, and (3) the amount of penicillin required to achieve and maintain the desired concentration according to the route of administration that has been selected. The required concentration can be determined by testing the organisms in vitro against different concentrations of penicillin. In general, it is known that the gonococci and meningococci are the most susceptible of the affected organisms. They are followed, in order of increasing resistance, by *pneumococcus, Streptococcus hemolyticus* (Group A), *Staphylococcus aureus, Streptococcus viridans, Staphylococcus albus,* and the Gram-positive rods.[5,7] Rammelkamp and Keefer,[12] who have tested the resistance of a number of strains of staphylococci and hemolytic streptococci, found that after the intravenous administration of penicillin blood exerted its maximum bactericidal effect against the hemolytic streptococcus when the serum concentration was between 0.019 and 0.156 Oxford units per c.c. For the maximum bacteriostatic effect against the *Staphylococcus aureus,* serum concentrations of 0.156 Oxford units per c.c. were required.

After arriving at some estimate of the concentration required either systemically in cases of generalized infection or locally in cases of localized infection, one must consider the possible routes of administration and the dosage required. These questions are complicated by the lack of a simple method of measuring the concentration of penicillin in body fluids. There is

no chemical test, as there is with the sulfonamides, for determining the amount of penicillin in the blood, and it is necessary to resort to biological tests. The blood concentrations of penicillin in terms of Oxford units can be determined by testing the power of the blood to inhibit a standard strain of hemolytic streptococci.

Penicillin can be administered intravenously, intramuscularly, intrathecally, intrapleurally, intra-articularly, intrapericardially, or intraperitoneally. The hydrochloric acid of the stomach destroys penicillin so that it cannot be given by mouth. Attempts have been made to administer it by duodenal tube or in enteric coated capsules, but the attempts have not been very successful. The Gram-negative organisms are able to destroy penicillin so that rectal administration likewise is not satisfactory.

The intravenous route has received the greatest attention. Penicillin may be given in the form of a continuous intravenous infusion or as intermittent venous injections. A continuous infusion is the better way to administer penicillin because by this method its introduction can keep pace with excretion, and the blood level can be kept fairly constant. Rammelkamp and Keefer[13] have shown that penicillin disappears rapidly from the blood stream following intravenous injection. In general, about 75 per cent of the injected material leaves the blood stream within 15 minutes and 90 per cent by the end of 30 minutes. The remaining 10 per cent disappears slowly over the course of two or three hours. The rapid disappearance from the blood is associated with rapid excretion of the drug in the urine. In the presence of impaired kidney function penicillin is not excreted so rapidly, and the blood concentration remains high for considerable time. Though most of the penicillin is excreted in the urine, a portion of the injected dose is probably excreted in the bile and the saliva. Some of that excreted in the bile can be reabsorbed; the remainder is destroyed by the intestinal bacteria.

Because of the difficulties involved in intravenous administration, many workers have resorted to intramuscular injection. Penicillin is rapidly absorbed after intramuscular injection so that the blood concentration reaches fairly high levels in 15 to 30 minutes. The high level is then maintained for 15 to 30 minutes, after which it gradually falls until only traces of penicillin can be detected in the blood after three to four hours. A single intravenous dose of 10,000 to 40,000 Oxford units may be expected to result in a blood concentration between 0.078 and 0.312 Oxford units per c.c. at 30 minutes, 0.019 and 0.078 Oxford units at 60 minutes, and 0.0 and 0.009 Oxford units at two hours. A single intramuscular dose of 10,000 Oxford units may be expected to result in a blood level between 0.078 and 0.015 Oxford units per c.c. at 15 and 30 minutes, 0.039 and 0.078 at 60 minutes, and 0.0 and 0.009 at two hours. A larger dose will give higher levels for a longer period following either intramuscular or intravenous injection.

Penicillin does not penetrate into the spinal fluid of normal individuals[13] nor into the tears or pancreatic juice.[1,6] Rammelkamp and Keefer[14] have injected penicillin intrathecally in normal subjects and in those with meningitis. In both instances penicillin was absorbed and excreted in the urine, but the absorption was more rapid in patients with meningitis than in normal persons. A dose of 10,000 units caused some irritation as evidenced by increased cell count, increased cerebrospinal fluid pressure, and headache; traces of penicillin were detected in the cerebrospinal fluid for 31.5 hours. A dose of 5,000 units caused only very mild changes. Penicillin injected in normal patients cannot be recovered from the cerebrospinal fluid in any significant concentration.[13] It is not known whether penicillin injected into the blood stream will penetrate into the cerebrospinal fluid of patients with meningitis. Until this is determined, penicillin should be injected into the subarachnoid space in patients with meningitis in doses of 5-10,000 units every 24 hours.

Intermittent subcutaneous injections of penicillin are absorbed very slowly, and a satisfactory blood level is not obtained.

Intravenous or intramuscular injections of penicillin do not penetrate into walled-off collections of pus such as may be found in thoracic empyema or in a septic joint. Conversely, penicillin injected directly into such an abscess does not escape rapidly.[6,14] In such conditions, therefore, penicillin should be injected directly into the abscess once daily. The pus should be aspirated and the drug injected in amounts sufficient to produce a concentration of several Oxford units per c.c. of abscess content.

It will require increasing experience to delineate accurately the optimal dosage of penicillin

for various infections. It is worth emphasizing that to date the supply of penicillin has been so limited that most effort has been directed toward ascertaining the minimum amount that would be effective in a given case. In only a few instances have really large doses been employed. It is not known, therefore, what results might be obtained with massive doses. At present it seems wise to guide therapy by testing the resistance of the organism in question and then administering enough penicillin frequently enough to keep the blood level close to the concentration required to inhibit the growth of the organism in vitro. There is some experimental work[12] to indicate that it may not always be necessary to maintain such high levels, but until this has been established, it is safer to overcompensate.

The following dosage schedule has been tentatively advanced by Lyons[11] for the treatment of surgical infections:

Susceptible streptococcal infections
15,000 Oxford units intramuscularly every four hours
Staphylococcal infections with bacteremia
25,000 units intravenously initially and
5,000 or 7,500 units intravenously every one-half hour
Staphylococcal infections without bacteremia
25,000 units intravenously every three hours.

These doses are somewhat higher than those recommended by other observers[5,10] and may reflect the needs of a different type of patient. In general, it is known that simple cellulitis or cellulitis with bacteremia responds fairly well to moderate doses.

Infections characterized by well-walled-off abscesses or the presence of necrotic tissue do not respond well to treatment with penicillin alone. Penicillin does not seem to penetrate well into collections of pus surrounded by thick fibrous walls. Dead tissue, especially bone and foreign bodies, protects bacteria. While penicillin will alleviate the systemic toxic manifestations of these infections, it will not cure the local lesion; if penicillin treatment is stopped before the dead bone and foreign bodies have been removed surgically, the infection will undergo a recrudescence. The drug does *not eliminate* the necessity for good surgical treatment though it aids considerably in preparing the patient for operation by eliminating the systemic toxic manifestations.

To date penicillin has been employed in a wide variety of surgical infections. It is not feasible to review all of them at this time. In general, it may be said that its effect on most cases of simple staphylococcal infection or staphylococcal infection complicated by bacteremia is usually excellent provided treatment is instituted early enough and in adequate doses. In acute osteomyelitis the results are equally impressive, provided treatment is started before destruction of considerable bone has occurred. Treatment of chronic osteomyelitis has been disappointing for those who hoped to avoid surgery. On the other hand, it has been quite satisfactory for those who acquiesced to the removal of sequestra, sinus tracts, and dead bone during the course of therapy.

Pneumococcal, staphylococcal, and streptococcal empyemæ have been cured in some instances without rib resection when penicillin was placed directly into the empyema cavity.[15] It has been of benefit in staphylococcal empyema and in empyema caused by a mixture of anaerobic organisms. There is some evidence to show that the mixed anaerobic infections, such as lung abscess, Ludwig's angina, and bronchiectasis, will respond favorably to large doses of penicillin. To date a sufficient number of these cases has not been treated with adequate doses to justify a final conclusion.

Hemolytic streptococcal infections respond almost dramatically to penicillin, but since most of them are susceptible to sulfonamide therapy, no large number has been treated.

Mixed infections, especially those resulting from war wounds and compound fractures, are more resistant to therapy than those infections caused by a single organism. These infections present a paramount surgical problem. Lyons[11] has shown that they will respond to penicillin if the drug is used in conjunction with adequate surgical therapy. The patient should receive perhaps a week of penicillin therapy plus drainage of any obvious abscess; next the wound should be revised and all dead bone, scar tissue, and foreign bodies removed; then penicillin should be continued until the wound is well healed or obviously well on the way to recovery.

Penicillin promises to be an aid in the skin grafting of third degree burns. Skin grafts fail to take because of infection, lack of proper contact between the graft and the granulating bed, and poor blood supply in the granulating bed. By controlling infection with the Gram-positive

(Continued on Page 618)

Is There Another Side to Medicine?



President's Page

For years, we have talked about the art and science of medicine. Because of years of study, research, and the trial and error method, American Medicine has developed to a most enviable place among the nations of the world. We have developed magnificent programs for continuation studies and are definitely showing the results of these studies.

The advances in public health, in industrial health, the lowered mortality in many diseases, and now the startling results of chemotherapy speak for the science of medicine. While we have been so engrossed in this scientific field, I fear we have lost sight of some of the social and economic phases of medicine. All about us there is a rapidly changing world. Other professions and other businesses have branched out into the social and economic fields which affect their lines of endeavor.

In medicine, for too long we have stood aloof on this other side of medicine, too long have we been the untouchables, too long have we said we are a scientific group. Now that we are being confronted by politicians and bureaus, the shoe is beginning to pinch. The present time calls for united action. We can no longer be just a scientific group, we must be a business league as well. This is not just a problem for the Michigan State Medical Society, but for all the states which comprise the American Medical Association.

C. R. Keyport

President, Michigan State Medical Society

EDITORIAL

POSTWAR PLANS

■ The first and most important project for all of us now is to win the war. To that end we are devoting our most strenuous energies. Everything must be subordinate to the national need. From every standpoint, and for every person, be he laborer, business or professional man, there is the one all-absorbing goal. For that accomplishment we must accept the guidance and the leadership of those placed in authority. There must be central guidance or there will be chaos.

But our experience is that bureaucrats, when given a little authority, always grasp for more, seeking to increase and perpetuate that authority. In coöperating with them for the necessary war efforts, and in accepting their leadership in accomplishing the all-important end, we must not give up our hard-earned advancements and well-established institutions. Our schools must remain independent, our societies voluntary and progressive, and our lives and ideals our own. The schools and societies we must preserve or they will be taken over and dominated by hierarchy to our disadvantage and to the great progress of bureaucracy.

The medical schools are already almost absorbed by the military, but an announcement has just been made that premedical students will not be deferred after July 1, 1944. Again the classes and curriculum are disrupted. Britain did not disturb the ordinary course of professional education, but left it independent, not dominated by the military. Soviet Russia did condense and shorten courses, cutting two years off the medical training, but in 1942 abandoned the plan, having found that it takes about the regular time for proper training of doctors of medicine. Our medical schools are concerned as to their future.

The Michigan State Medical Society committees on Postgraduate Extension and on Postgraduate Medical Education are working on instruction plans to bring the war doctor up to date on the home front practice of medicine, in which he will have grown rusty in his three or more years of war medicine. But the war doctor will also have something to teach the stay-at-home. There have been great advances in their methods and experiences which the civilian doctor can convert to his own use. Neither the military doctor nor the stay-at-home will have all the advantages, nor all the disadvantages. Many of us were in the First World War, and would not give up numerous lessons that have served us well since returning to civil practice. This will hold in this war also, and the committees should remember that in their planning.

Early in the war it was charged by those who were trying to build an army that the medical profession was not making the proper contribution to "the war effort." We were trying to do a service to the war as well as to civilian practice, in securing for private service enough essential men so the home front would not suffer too great shortages. Our efforts were sadly needed. Just recently we were accused of "contributing nothing constructive and opposing all constructive effort."

Let us view the record. The Michigan State Medical Society has a maximum membership of 4,786 and we have 1,783 members in the military services; also 392 nonmembers, mainly residents and interns. Any organization which has put 40 per cent of its membership into the armed forces can scarcely be accused of noninterest. But that is just the beginning. There are other hundreds, yes thousands, who have worked in season and out for over three years helping with the draft examinations (which have now been put where they should have been all the time, at the induction centers). The men still left in home practice are carrying on the work of their comrades as well as their own. The hours are long and busy, the pace much more exacting than military service with the exception of sacrifice of home comforts and the hazards of war.

But that is self-evident. Has anything constructive been done? Michigan Medical Service was established to prove that good surgical service can be within the reach of all and at predetermined fixed costs, giving the patient his choice of doctor, and all serviced by voluntary

effort, independent of bureaucracy. This was a pure experiment in untried fields, with no beaten paths and no guiding hand. There were growing pains, mistakes and misguided efforts. Within the past month Michigan Medical Service has announced its favorable experience in converting a staggering deficiency into a surplus. During its trying days of 1941 it was necessary to prorate the payments to the doctors, under the plan that had been worked out. Twenty per cent of payments were deducted. That has all been repaid. Checks have been sent to 3,210 doctors in amounts ranging from $.40 to just under a thousand dollars. More than one person in every five in the state of Michigan is protected from the catastrophic expense of sickness by Michigan Medical Service. There has been an increasing demand for further protection, and certificates are now being prepared and studies are far under way to give *all medical care in the hospital.* These plans and programs cannot just be *made,* as we found out to our great regret, when the plan was first started. Costly mistakes must not be made again. Progress is faster if it is sufficiently deliberate and secure.

Another postwar plan that must take a prominent place in our thinking, and which in the past has been ignored is public education. We must never again live unto ourselves even though while doing so we have produced the most healthy nation on earth, the lowest mortality records, and the most ideally trained medical profession. Progress must be publicized. The people must know our triumphs, our ideals, our methods and means of study that have made the unprecedented growth of the past few decades. If more attention had been given to publicizing our ideals instead of enjoying them *in spiritu suis,* many of our present troubles just would not have happened.

We need a book.

DOCTORS FOR THE POSTWAR PERIOD

■ We have several times called attention to the needs for the future of well-trained medical men to carry on the work of looking after the health of our people, and questioned where the premedical students would come from, and if it were not essential to look to the future in our planning. The persons in charge of recruiting an army and navy have held their special job uppermost. They have virtually taken over the conduct of medical education, filling all but 20 per cent of the available student places in the medical schools, and leaving that group for women and and the physically unfit men rejected by the military.

An elaborate Army Specialized Training Program was set up, but was curtailed in April, 1944. A portion of the medical part of that program was retained with an announcement that premedical students actually enrolled in classes by July 1, 1944, would be allowed to continue; all others would be taken into the armed forces.

The Journal of the American Medical Association for June 10, 1944, calls attention to this situation and quotes the Secretary of War and the Secretary of the Navy jointly as advising the War Manpower Commission on May 16, that "the immediate needs of the war for their (students) services ought not to yield to the prospective use of them as doctors in 1949 or thereafter, particularly when it is to be expected that the course of the war will make it possible to release many doctors now in military service."

The Army will furnish 1,790 students and the Navy 1,540 for the entering classes of 1945, leaving 3,110 vacancies to be filled by women and men disqualified for military service. For the natural growth of the profession we need replacements of about 6,500 each year. About 3,500 doctors die each year, and there will be increased needs for many years because of the lessened numbers trained by the various nations affected by the war. It seems shortsighted to close the future opportunities of young men for the study of medicine in order to get a paltry few thousand young soldiers into uniform. It is the part of intelligence and foresightedness not to give up a present real advantage in order to obtain a future presumed advantage. We must win the war, but we must as surely win the peace, and part of the peace is to insure the national health.

RADIO AND PATENT MEDICINES

■ On May 13, 1944, *The Journal of the American Medical Association* called upon the radio industry to emulate the leading newspapers and eliminate the exploitation of the sick through "patent medicine" advertising. The comments were stimulated by the report of illness from use of a nationally advertised headache powder

of two men who had chronic bromide poisoning.

If anyone doubts the rankness of the radio advertising of "patent medicines" it is only necessary to turn on his radio and listen for a half day, if he can find the half day. The stations are practically all filled with such advertising. "Hour after hour, day after day, loud speakers of radios blare forth outrageous claims for some nostrum or patent home remedy. The 'patent' remedies advertised range from those that may be positively harmful, to those that are merely grossly overpriced in relation to their value."

INDUSTRIAL MEDICINE AND SURGERY

■ The Second Annual Conference on Postgraduate Industrial Medicine and Surgery was held at the Rackham Educational Memorial Building, Detroit, on April 6, 1944. The attendance and enthusiasm confirmed the wisdom and value of this program sponsored by the Committee on Industrial Health of the Michigan State Medical Society and the Michigan Association of Industrial Physicians and Surgeons, in coöperation with the Department of Postgraduate Medical Education of the University of Michigan and the Wayne University College of Medicine. The papers were all presented as announced and were of unusually high quality.

In this issue of THE JOURNAL we present several of the papers. They are deserving of study. Physicians and surgeons interested in industrial medicine will find these annual meetings profitable. We congratulate the committee which made the arrangements and prepared the program, and especially Kenneth E. Markuson, M.D., the chairman.

ATTENTION!

■ A new application of the urge to socialize the medical and health services has just (June 29) come to our attention, too late for careful study and judicious comment. There has just been announced an amendment to Article VI of the Constitution of the State of Michigan, adding a new Section 23 setting up a social arrangement far more extensive than the Wagner-Murray-Dingell effusion. The new section fills ten closely typed pages. Petitions are prepared to place this on referendum, but the strategy might be to bring it to vote at the spring elections when a much smaller number would be necessary to carry (a majority of the votes cast).

"All persons who have their normal residence in Michigan shall be qualified to receive health insurance benefits" which are specified "(a) Medical, Surgical, and Obstetrical benefits, (b) Dental benefits, (c) Pharmaceutical benefit, (d) Hospital benefit, and (e) Nursing benefit." Workmen's compensation and old age benefit are assigned to this service.

The employer must deduct one per cent from the net income of his employe up to $5,000, two per cent up to $20,000 and three per cent on incomes over $20,000, to which he shall add one and a half per cent of his gross payroll. This service is to be administered by a commissioner appointed by the Governor, and a commission of nine. "The legislature shall have the power to pledge the credit of the State for the projects and purposes of this section."

This is legislation by amendment, and the strategy could pass it much easier than to pass the Wagner-Murray-Dingell Bill. It was filed by an attorney.

ON THE RUN

Intermittent attacks of renal colic, with finding of calculi, should suggest hyperparathyriodism.

Present evidence indicates that loss of pancreatic juices does not result in fatty infiltration of the liver.

In intravenous therapy, moist heat locally is best for distending small or poorly-filled veins.

Intussusception of the bowel in adults is quite often caused by tumors of the bowel, principally the benign forms.

Suppositories of aminophyllin have been found helpful in bronchial asthma.

Phonidling: Guesswhoing the busy doctor for play-by-play progress reports on patients.

Persistent postoperative cholecystectomy symptoms may be due to residual inflammation of the biliary tract.

A precipitous drop in body temperature at any time during the last half of the intermenstrual cycle indicates the onset of menstruation in one to three days.

Smoking on an empty stomach just before x-ray study of the gastro-intestinal tract may disturb functional behavior and diminish the value of the test.

In cerebral concussion, the physical intracellular disorder can surpass other complications and cause persistent intellectual defect.

Chlorellin, from a freshwater alga, *Chlorella,* produces effects much like those of penicillin.

Anthiomaline (lithium antimony thiomalate), appears to be of therapeutic value in lymphogranuloma venereum and schistostomiasis.

Gamma globulin, fractionated from blood plasma, contains measles antibodies making it an excellent prophylactic against this disease.

Severe damage is present when cerebral trauma is accompanied by confusion lasting more than twenty-four hours.

Pain is not always a reliable or timely diagnostic symptom in prostatic carcinoma.

Selected by W. S. REVENO

THE 79th ANNUAL SESSION

1944 Postgraduate Conference on War Medicine

Grand Rapids



V. M. Moore, M.D.
Grand Rapids
Chairman of Council



C. R. Keyport, M.D.
Grayling
President



P. L. Ledwidge, M.D.
Detroit
Speaker, House of Delegates

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Grand Rapids, Michigan, on September 25, 26, 27, 28, and 29, 1944. The provisions of the Constitution and By-laws and the Official Program will govern the deliberations.

C. R. Keyport, M.D.
President

V. M. Moore, M.D.
Council Chairman

P. L. Ledwidge, M.D.
Speaker

E. A. Oakes, M.D.
Vice Speaker

Attest:
L. Fernald Foster, M.D.
Secretary



L. Fernald Foster, M.D.
Bay City
Secretary



Wm A. Hyland, M.D.
Grand Rapids
Treasurer

Two-Day Session of House of Delegates, September 25-26

The 1944 House of Delegates of the Michigan State Medical Society will hold a two-day session, beginning Monday, September 25, at 8:00 p.m. The business of the House will be transacted in the ballroom of the Pantlind Hotel, Grand Rapids.

The House will also meet Tuesday, September 26 at 10:00 a.m. and at 8:00 p.m. The intervals between meetings of the House of Delegates have been spaced to permit the reference committees ample time to transact all business referred to them.

Such additional meetings as may be necessary will be held Wednesday, September 27, beginning at 10:00 a.m.

Seating of Delegates

"Any Delegate-Elect not present to be seated at the hour of call of the First Session may be replaced by an accredited alternate next on the list as certified by the Secretary of the County Medical Society involved."

—MSMS By-Laws, Chapter 3, Section 3.

HOUSE OF DELEGATES, 1944

Ballroom, Pantlind Hotel, Grand Rapids

ORDER OF BUSINESS*

MONDAY, SEPTEMBER 25

8:00 p.m.—First Meeting

1. Call to order by Speaker
2. Report of Committee on Credentials
3. Roll Call
4. Appointment of Reference Committees:
   - (a) On Officers' Reports
   - (b) On Reports of The Council
   - (c) On Reports of Standing Committees
   - (d) On Reports of Special Committees
   - (e) On Amendments to Constitution and By-Laws
   - (f) On Resolutions
5. Speaker's Address—P. L. Ledwidge, M.D., Detriot
6. President's Address—C. R. Keyport, M.D., Grayling
7. President-Elect's Address—A. S. Brunk, M.D., Detroit
8. Annual Report of The Council—V. M. Moore, M.D., Grand Rapids, Chairman
9. Report of Delegates to American Medical Association—Henry A. Luce, M.D., Detroit, Chairman
10. Resolutions**
11. Reports of Standing Committees:
    - (a) Legislative Committee
    - (b) Committee on Distribution of Medical Care
    - (c) Representatives to Joint Committee on Health Education
    - (d) Medical-legal Committee
    - (e) Preventive Medicine Committee
      Cancer
      Maternal Health
      Venereal Disease Control
      Tuberclosis Control
      Industrial Health
      Mental Hygiene
      Child Welfare
      Iodized Salt
      Heart and Degenerative Diseases
    - (f) Committee on Postgraduate Medical Education
    - (g) Committee on Public Relations
    - (h) Committee on Ethics
12. Reports of Special Committees:
    - (a) Committee on Nurses' Training Schools
    - (b) Conference Committee on Prelicensure Medical Education
    - (c) Radio Committee
    - (d) Advisory Committee to Woman's Auxiliary
    - (e) Scientific Work Committee
    - (f) Professional Liaison Committee
    - (g) Beaumont Memorial Committee
    - (h) Committee on Procurement and Assignment of M.D.'s
    - (i) Postgraduate Extension Committee
    - (j) Joint Committee with State Bar of Michigan

Recess

TUESDAY, SEPTEMBER 26

10:00 a.m.—Second Meeting

1. Supplementary Report of Committee on Credentials
2. Roll Call
3. Unfinished Business
4. New Business†
5. Reports of Reference Committees:
   - (a) On Officers' Reports
   - (b) On Reports of The Council
   - (c) On Reports of Standing Committee
   - (d) On Reports of Special Committees
   - (e) On Amendments to Constitution and By-Laws
   - (f) On Resolutions

Recess

TUESDAY, SEPTEMBER 26

8:00 p.m.—Third Meeting

1. Supplementary Report of Committee on Credentials
2. Roll Call
3. Unfinished Business
4. Supplementary Report of The Council
5. Supplementary Report of Reference Committees
6. Elections
   - (a) Councilor:
     14th District—Dean W. Myers, M.D., Ann Arbor—Incumbent
   - (b) Delegates to American Medical Association:
     Henry A. Luce, M.D., Detroit—Incumbent
     T. K. Gruber, M.D., Eloise—Incumbent
     Claude R. Keyport, M.D., Grayling—Incumbent
   - (c) Alternate Delegates to American Medical Association:
     C. S. Gorsline, M.D., Battle Creek—Incumbent
     Carl F. Snapp, M.D., Grand Rapids—Incumbent
     R. H. Denham, M.D., Grand Rapids—Incumbent
   - (d) President-Elect
   - (e) Speaker of House of Delegates
   - (f) Vice speaker of House of Delegates

Adjournment

*See the Constitution, Article IV, and the By-Laws, Chapter 3, on "House of Delegates."

**All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 3, Section 7-n).

†All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 3, Section 7-n).

DELEGATES TO MSMS HOUSE OF DELEGATES

Names of Alternates Appear in Italics

Officers
P. L. Ledwidge, M.D.
Detroit, *Speaker*
E. A. Oakes, M.D.
Manistee, *Vice Speaker*
L. Fernald Foster, M.D.
Bay City, *Secretary*
H. H. Cummings, M.D.
Ann Arbor, *Immediate Past President*

Allegan
W. C. Medill, M.D., Plainwell
J. E. Mahan, M.D., Allegan

Alpena-Alcona-Presque Isle
W. E. Nesbitt, M.D., Alpena
F. J. O'Donnell, M.D., Alpena

Barry
C. A. E. Lund, M.D., Hastings
C. P. Lathrop, M.D., Hastings

Bay-Arenac-Gladwin-Iosco
C. L. Hess, M.D., Bay City
F. H. Drummond, M.D., Kawkawlin
G. M. Brown, M.D., Bay City
R. N. Sherman, M.D., Bay City

Berrien
D. W. Thorup, M.D., Benton Harbor
R. C. Conybeare, M.D., Benton Harbor

Branch
R. L. Wade, M.D., Coldwater
N. J. Walton, M.D., Quincy

Calhoun
A. T. Hafford, M.D., Albion
H. C. Hansen, Major, M.C., Keesler Field, Miss.
B. G. Holtom, M.D., Battle Creek
G. W. Slagle, M.C., Parris Island, South Carolina

Cass
S. L. Loupee, M.D., Dowagiac

Chippewa-Mackinac
B. T. Montgomery, M.D., Sault Ste. Marie
Clayton Willison, M.D., Sault Ste. Marie

Clinton
W. B. McWilliams, M.D., Maple Rapids
G. H. Frace, M.D., St. Johns

Delta-Schoolcraft
J. J. Walch, M.D., Escanaba
N. J. Frenn, M.D., Bark River

Dickinson-Iron
L. E. Irvine, M.D., Iron River
W. H. Alexander, M.D., Iron Mountain

Eaton
P. H. Engle, M.D., Olivet
C. J. Sevener, M.D., Charlotte

Genesee
D. R. Braise, M.D., Flint
F. E. Reeder, M.D., Flint
Henry Cook, M.D., Flint
A. C. Pfeifer, M.D., Mt. Morris
M. S. Chambers, M.D., Flint
A. D. Kirk, M.D., Flint
J. T. Connell, M.D., Flint
D. R. Wright, M.D., Flint

Gogebic
W. E. Tew, M.D., Bessemer
H. T. Nezworski, M.D., Ramsey

Grand Traverse-Leelanau-Benzie
R. T. Lossman, M.D., Traverse City
H. B. Kyselka, M.D., Traverse City

Gratiot-Isabella-Clare
M. G. Becker, M.D., Edmore

Hillsdale
L. W. Day, M. D., Jonesville
O. G. McFarland, M.D., North Adams

Houghton-Baraga-Keweenaw
W. A. Manthei, M. D., Lake Linden
Alfred LaBine, M.D., Houghton

Huron
C. W. Oakes, M.D., Harbor Beach
W. B. Holdship, M.D., Ubly

Ingham
C. F. DeVries, M.D., Lansing
L. G. Christian, M.D., Lansing
R. S. Breakey, M.D., Lansing
J. O. Wetzel, M.D., Lansing
H. W. Wiley, M.D., Lansing
Milton Shaw, M.D., Lansing

Ionia-Montcalm
W. L. Bird, M.D., Greenville
O. P. Geib, M.D., Carson City

Jackson
J. J. O'Meara, M.D., Jackson
C. S. Clarke, M.D., Jackson
C. R. Dengler, M.D., Jackson

Kalamazoo
R. J. Armstrong, M.D., Kalamazoo
L. W. Gerstner, M.D., Kalamazoo
U. S. Gregg, M.D., Kalamazoo
J. D. Littig, M.D., Kalamazoo

Kent
R. H. Denham, M.D., Grand Rapids
L. E. Sevey, M.D., Grand Rapids
A. B. Smith, M.D., Grand Rapids
A. V. Wenger, M.D., Grand Rapids
C. F. Snapp, M.D., Grand Rapids
W. B. Mitchell, M.D., Grand Rapids
P. W. Willits, M.D., Grand Rapids
W. R. Torgerson, M.D., Grand Rapids
S. L. Moleski, M.D., Grand Rapids
J. W. Logie, M.D., Grand Rapids

Lapeer
D. J. O'Brien, M.D., Lapeer
H. M. Best, M.D., Lapeer

Lenawee
E. T. Morden, M.D., Adrian
W. S. Mackenzie, M.D., Adrian

Livingston
H. L. Sigler, M.D., Howell
E. D. Finch, M.D. Howell

Luce
H. E. Perry, M.D., Newberry
R. E. Spinks, M.D., Newberry

Macomb
A. B. Bower, M.D., Armada
W. A. Sibrans, M.D., East Detroit

Manistee
E. A. Oakes, M.D., Manistee
E. B. Miller, M.D., Manistee

Marquette-Alger
V. H. Vandeventer, M.D., Ishpeming
R. A. Burke, M.D., Negaunee

Mason
C. A. Paukstis, M.D., Ludington
W. S. Martin, M.D., Ludington

Mecosta-Osceola-Lake
G. H. Yeo, M.D., Big Rapids
P. B. Kilmer, M.D., Reed City

Medical Society of North Central Counties
(Otsego-Montmorency-Crawford-Oscoda-Roscommon-Ogemaw)
R. C. Peckham, M.D., Gaylord
H. M. Jardine, M.D., West Branch

Menominee
H. T. Sethney, M.D., Menominee
W. S. Jones, M.D., Menominee

Midland
I. M. Howe, M.D., Midland
W. D. Towsley, M.D., Midland

Monroe
T. A. McDonald, M.D., Monroe
B. J. Fieldhouse, M.D., Monroe

Muskegon
E. N. D'Alcorn, M.D., Muskegon
H. D. Dykhuisen, M.D., Muskegon

Newaygo
H. R. Moore, M.D., Newaygo

Northern Michigan
(Antrim-Charlevoix-Emmet-Cheboygan)
Geo. Wood, M.D., Detroit
W. H. Mast, M.D., Petoskey

Oakland
R. H. Baker, M.D., Pontiac
P. E. Sutton, M.D., Royal Oak
J. S. Lambie, M.D., Birmingham
Z. R. Aschen Brenner, M.D., Farmington
L. F. Cobb, M.D., Pontiac
M. M. Jones, M.D., Dayton Plains

Oceana
M. G. Wood, M.D., Hart
J. H. Nicholson, M.D., Hart

Ontonagon
W. F. Strong, M.D., Ontonagon
H. B. Hogue, M.D., Ewen

Ottawa
A. E. Stickley, M.D., Coopersville
D. C. Bloemendaal, M.D., Zeeland

Saginaw
C. E. Toshach, M.D., Saginaw
L. C. Harvie, M.D., Saginaw
A. J. Cortopassi, M.D., Saginaw
D. C. Durman, M.D., Saginaw

Sanilac
R. K. Hart, M.D., Croswell
N. J. Ellis, M.D., Croswell

Shiawassee
C. L. Weston, M.D., Owosso
H. A. Hume, M.D., Owosso

St. Clair
George Waters, M.D., Pt. Huron
W. A. Schaefer, M.D., Pt. Huron

St. Joseph
R. A. Springer, M.D., Centerville
R. J. Fortner, M.D., Three Rivers

Tuscola
T. E. Hoffman, M.D., Vassar
J. C. Shoemaker, M.D., Vassar

Van Buren
W. R. Young, M.D., Lawton
J. C. Maxwell, M.D., Paw Paw

Washtenaw
J. A. Wessinger, M.D., Ann Arbor
H. M. Beebe, M.D., Ann Arbor
R. N. DeJong, M.D., Ann Arbor
J. S. DeTar, M.D., Milan
S. L. LaFever, M.D., Ann Arbor
M. E. Soller, M.D., Ypsilanti
H. R. Williams, M.D., Ann Arbor
John Sundwall, M.D., Ann Arbor

Wayne
W. D. Barrett, M.D., Detroit
G. L. McClellan, M.D., Detroit
S. W. Insley, M.D., Detroit
R. L. Novy, M.D., Detroit
A. E. Catherwood, M.D., Detroit
H. F. Dibble, M.D., Detroit
L. W. Hull, M.D., Detroit
T. K. Gruber, M.D., Eloise
R. H. Pino, M.D., Detroit
H. A. Luce, M.D., Detroit
D. C. Beaver, M.D., Detroit
C. D. Brooks, M.D., Detroit
F. G. Buesser, M.D., Detroit
W. H. Honor, M.D., Detroit
W. B. Cooksey, M.D., Detroit
R. C. Jamieson, M.D., Detroit
C. E. Dutchess, M.D., Detroit
R. V. Walker, M.D., Detroit
L. J. Morand, M.D., Detroit
W. J. Stapleton, M.D., Detroit
W. W. Babcock, M.D., Detroit
W. B. Harm, M.D., Detroit
L. J. Bailey, M.D., Detroit
W. S. Reveno, M.D., Detroit
C. F. Brunk, M.D., Detroit
E. R. Witwer, M.D., Detroit
M. A. Darling, M.D., Detroit
C. K. Hasley, M.D., Detroit
C. E. Simpson, M.D., Detroit
B. H. Douglas, M.D., Detroit
E. G. Krieg, M.D., Detroit
Arch Walls, M.D., Detroit
T. G. Amos, M.D., Detroit
V. N. Butler, M.D., Detroit
A. F. Jennings, M.D., Detroit

R. A. Johnson, M.D., Detroit
J. A. Kasper, M.D., Detroit
H. L. Clark, M.D., Detroit
C. S. Ratigan, M.D., Detroit
Duncan Campbell, M.D., Detroit
W. S. Gonne, M.D., Detroit
F. A. Weiser, M.D., Detroit
H. W. Plaggemeyer, M.D., Detroit
J. E. Cole, M.D., Detroit
R. C. Connelly, M.D., Detroit
J. H. Andries, M.D., Detroit
S. E. Gould, M.D., Eloise
L. T. Henderson, M.D., Detroit
D. I. Sugar, M.D., Detroit
W. P. Woodworth, M.D., Detroit
R. M. Athay, M.D., Detroit
W. P. Chester, M.D., Detroit
W. A. Chipman, M.D., Detroit
Wm. Hamilton, M.D., Detroit
B. C. Lockwood, M.D., Detroit
J. H. Law, M.D., Detroit
W. N. Braley, M.D., Detroit
A. V. Forrester, M.D., Detroit
M. H. Hoffman, M.D., Detroit
W. W. MacGregor, M.D., Detroit
B. L. Connelly, M.D., Detroit
C. L. Candler, M.D., Detroit
G. L. Coan, M.D., Detroit
J. K. Bell, M.D., Detroit
S. A. Flaherty, M.D., Detroit
F. W. Hartman, M.D., Detroit
Joseph Hickey, M.D., Detroit
E. H. Lauppe, M.D., Detroit
J. J. Lightbody, M.D., Detroit
H. L. Morris, M.D., Detroit
H. A. Pearse, M.D., Detroit
L. J. Gariepy, M.D., Detroit
R. H. Bookmyer, M.D., Detroit
D. A. Cohoe, M.D., Detroit
L. O. Geib, M.D., Detroit
G. B. Hoops, M.D., Detroit
W. R. McClure, M.D., Detroit
Jack Agins, M.D., Detroit
E. M. Vardon, M.D., Detroit
A. H. Bracken, M.D., Detroit
Meshel Rice, M.D., Detroit
J. B. Rieger, M.D., Detroit

Wexford-Missaukee-Kalkaska

W. J. Smith, M.D., Cadillac
C. E. Merritt, M.D., Manton

HOUSE OF DELEGATES, 1944

REFERENCE COMMITTEES

Credentials Committee

J. J. O'Meara, M.D., **Chairman**
Warren W. Babcock, M.D.
T. A. McDonald, M.D.
H. T. Sethney, M.D.
Arch Walls, M.D.

Officers' Reports

L. W. Day, M.D., **Chairman**
F. G. Buesser, M.D.
H. E. Hanson, M.D.
Ralph H. Pino, M.D.
D. W. Thorup, M.D.

Reports of the Council

Wyman D. Barrett, **Chairman**
W. L. Bird, M.D.
A. F. Jennings, M.D.
V. Van Deventer, M.D.
Hollis L. Sigler, M.D.
R. A. Springer, M.D.
George Waters, M.D.

Reports of Standing Committees

Donald C. Beaver, M.D., **Chairman**
M. G. Becker, M.D.
Milton A. Darling, M.D.
R. T. Lossman, M.D.
W. B. Harm, M.D.
W. E. Nesbitt, M.D.
Carl Ratigan, M.D.

Reports of Special Committees

A. V. Wenger, M.D., **Chairman**
L. W. Gerstner, M.D.
W. H. Honor, M.D.
L J. Morand, M.D.
C. W. Oakes, M.D.
D. J. O'Brien, M.D.
Richard Peckham, M.D.

Amendments to the Constitution and By-Laws

C. L. Hess, M.D., **Chairman**
Robert Breakey, M.D.
T. K. Gruber, M.D.
J. A. Kasper, M.D.
S. L. Loupee, M.D.

Resolutions

D R. Brasie, M.D., **Chairman**
Robert H. Baker, M.D.
John S. DeTar, M.D.
R. H. Denham, M.D.
Ford DeVries, M.D.
L. W. Hull, M.D.
Ralph A. Johnson, M.D.
G. L. McClellan, M.D.
R. L. Novy, M.D.

WHAT IT TAKES TO BE A DOCTOR OF MEDICINE

1. Four Years of High School
2. Two Years of College (including Physics, Chemistry, and Biology)
3. Four Years in a Medical College
4. One Year's Internship in a Hospital
5. A Knowledge of the Human Body. Its Normal Structures, Functions and Governing Laws
6. A Knowledge of All Common Diseases in Order to Know What Disease is Present
7. A Knowledge of Effective Remedial Agents. Ability to Apply the One Most Needed

THESE MINIMUM ESSENTIALS SHOULD BE POSSESSED BY
ALL WHO TREAT THE SICK

PROPOSED AMENDMENTS TO CONSTITUTION AND BY-LAWS OF MICHIGAN STATE MEDICAL SOCIETY

The following amendments to the Constitution were presented at the 1943 Annual Session of the House of Delegates, Michigan State Medical Society, and, according to the Constitution, were referred to the 1944 session of the House of Delegates for final consideration:

Constitution

1. Amend Article III, Section 4, by adding a new sub-paragraph to read as follows:

"Physicians, residents of the State of Michigan, for the period of time they are in active Military Service of the United States previous to their engaging in active practice."

COMMENT: This proposed amendment would make it possible for the County and State Societies to offer membership to Doctors of Medicine residing in Michigan who enter into active Military Service of the United States before engaging in private practice (such as interns and residents).

* * *

2. Amend Article III, Section 4, by adding a new sub-paragraph to read as follows:

"Active Members, by transfer, for the period of time they are temporarily out of active practice on account of protracted illness."

COMMENT: This proposed amendment would cover active members who may be unable to practice medicine for extended periods of time on account of protracted illness and who may either be ineligible for transfer to Retired Membership or be unable to pay annual dues.

* * *

3. Amend Article III, Section 4, Item 4, to read as follows:

"Physicians not engaged in any phase of medical practice, including members not in practice due to protracted illness."

COMMENT: This proposed amendment has the purpose as the proposed amendment No. 2.

* * *

4(a). Amend Article III by adding a new Section to be known as Section 8, to read as follows:

"Life Members. A physician who has attained the age of seventy years or more and maintained an active membership in good standing for ten years or more in the State Society may, upon application and recommendation of his County Society, be transferred to the Life Members' Roster by election in the House of Delegates. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing.

"The County Society of such member shall make request for certification, in writing, to the Secretary of the State Society thirty days or more in advance of the Annual Session."

4(b). Amend Article III, Section 1 by adding to the list of memberships the following:

"Life Members."

4(c). "BE IT RESOLVED that these amendments shall take effect and be incorporated in the Constitution at the Annual Session following the termination of the present World War."

COMMENT: A resolution was presented in 1942 recommending Emeritus Membership to members at the age of seventy years or more. The Committee on Constitution and By-Laws felt that Life Membership, as proposed above, would represent years of age while Emeritus Membership represents years of service; it also felt that any further reduction of active members paying dues, other than those in Military Service, would seriously reduce the income of the Society and included in its resolution that the above amendment to the Constitution, if approved, shall take effect at the Annual Session following the termination of the present World War.

* * *

5. Amend Article VIII, Section 2, to read as follows:

"The House of Delegates at each Annual Session shall elect the President-Elect, the Speaker and Vice Speaker of the House of Delegates, and the Councilors. These officers shall be installed in the general meeting at which the reports of the House of Delegates are received. They shall serve until the corresponding time of the next annual session except that the Councilors shall serve for five annual sessions. The terms of the Councilors shall be arranged so that not more than four terms expire normally at any annual session. All these officers shall serve until their successors are elected and take office.

"At the annual session next following his election the President-Elect shall be installed into and assume the office of Presidency immediately following the annual address by the retiring President and shall serve until the corresponding time of the next annual session. This assumption of office shall occur in the general meeting at which the reports of the House of Delegates are received.

"If no general meetings are held at the annual session, then induction into the office of the incoming president and the newly-elected officers shall be in the last meeting of the annual session of the House of Delegates.

"The Secretary, the Editor of the JOURNAL and the Treasurer shall be elected by the Council in its annual meeting in January of each year. They shall take office immediately and serve for a term of one year or until their successors are elected and take office."

COMMENT: This clarifies the election of the President-Elect who automatically becomes the President when the Presidency becomes vacant.

* * *

By-Laws

6. Amend Chapter 6, Section 9 to read as follows:

"The Committee on Ethics shall consist of five members appointed by the President with the approval of the Council to serve for five-year terms, so staggered that one member is selected annually, expect that in 1944 one member shall be selected for a five-year term, one for a four-year term, one for a three-year term, one for a two-year term, and one for a one-year term.

"If a member dies, resigns, or is disqualified prior to the expiration of his term, the President may appoint a successor to serve until the next meeting of the Council which, if it approves, may select him to serve the unexpired portion of the term.

"The following rights and duties devolve on the Committee:

"1. To render, on the request of the Council or of a component society, advisory opinions on questions of ethics submitted to it;

"2. To assist county societies in setting up schemes of integration between such county society committees as have duties and functions similar to the duties and functions of this committee and the Medico-Legal Committee of this Society:

"3. To integrate, so far as possible, its activities with the activities of the Medico-Legal Committee of this Society;

"4. On the request of a component society or of any member of this Society, to conduct such investigation or hearing, or both, as it deems appropriate, concerning the professional conduct of any member of this Society and to report to the component society to which the physician under inquiry belongs, its findings and conclusions as to the ethical propriety of the conduct in question for such further action as the component society may deem proper, provided however, that in the event of a finding adverse to the physician under inquiry if the physician agrees to amend his conduct to conform with the conclusions of ethical propriety made by the Committee, the Committee may in its discretion dispose of the matter and report its action to the appropriate component society;

"5. If a component society fails to institute disciplinary proceedings against a member with respect to whom the Committee has filed an adverse report, in its discretion to prefer written charges in the form and manner specified by the component society's organic laws with the secretary of the component society involved and, through a member or members of the Committee, to perform all acts that are reasonably necessary and proper in the prosecution of such charges; and

"6. To make annual reports to the State Secretary.

"A member who is guilty of any of the following acts shall be subject, in the discretion of the county society, to expulsion, suspension, or admonition:

"1. A criminal offense involving moral turpitude;

2. Gross misconduct as a physician or citizen;

3. Violation of the Principles of Medical Ethics;

4. The willful commission of any act tending to defeat the aims, purposes, or objects of this Society or to bring the Society into disrepute;

5. The willful refusal to adhere to the Constitution and By-Laws of the Society; or

6. The giving of any testimony in any court of law or administrative proceeding which in the opinion of the Council of the Society is reckless, willfully false or fraudulent, or is not in keeping with the dignity or scentific standards of the profession."

COMMENT: This proposed amendment, to clarify the duties of the MSMS Committee on Ethics, was considered briefly by the 1943 House of Delegates which referred it back to the Committee on Constitution and By-Laws for study.

Committee Reports

ANNUAL REPORT OF ETHICS COMMITTEE, 1943-44

The Ethics Committee respectfully reports that it has had more difficulty this year in one particular problem involving alleged breach of ethics than in all of the past three years. We certainly hope to have the matter settled by the time the "Handbook for Delegates" is printed. There has been only this one incident during the entire year.

Respectfully submitted,

Horace Wray Porter, M.D., *Chairman*
E. B. Anderson, M.D.
Guy D. Culver, M.D.
J. C. Grosjean, M.D.
L. C. Harvie, M.D.
Geo. B. Hoops, M.D.
Esli T. Morden, M.D.
LeMoyne Snyder, M.D.

●

ANNUAL REPORT OF BEAUMONT MEMORIAL COMMITTEE, 1943-44

The Beaumont Memorial Committee has not had a meeting this year.

The Early House on Mackinac Island where William Beaumont first treated his famous patient, Alexis St. Martin, has been purchased by Parke, Davis & Company and has been given to the Mackinac Island State Park Commission to hold as a public museum.

The objective of your Committee originally was to see that the Early House became the property of the State of Michigan. This has been accomplished, through the generosity of Parke, Davis & Company. The Chairman of your Committee wrote to W. F. Doyle, Chairman of the Mackinac Island State Park Commission, stating that the Beaumont Memorial Committee of the Michigan State Medical Society would be glad to coöperate with him in any way in efforts that might be made to restore the Early House or to make it a museum.

Respectfully submitted,

Frederick A. Coller, M.D., *Chairman*
F. C. Kidner, M.D.
H. C. Mayne, M.D.
Allan McDonald, M.D.
Lawrence Reynolds, M.D.

●

ANNUAL REPORT OF IODIZED SALT COMMITTEE, 1943-44

The Iodized Salt Committee has held no meetings, to June 1, 1944. However, a meeting during the summer months is probable as the Ten-Year Survey of surgical goiter cases in Michigan's seven largest hospitals is due in 1945. The survey of school children living in the four surveyed counties is also due in 1945. Ways and means will have to be sought for these surveys.

A supplemental report of the Iodized Salt Committee will be presented to the House of Delegates in September.

Respectfully submitted,

F. B. Miner, M.D., *Chairman*
T. B. Cooley, M.D.
L. W. Gerstner, M.D.
Dorman E. Lichty, M.D.
R. D. McClure, M.D.
R. J. Moehlig, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO WOMAN'S AUXILIARY, 1943-44

No meetings were requested and therefore no meetings were held. However, the President of the Woman's Auxiliary to the Michigan State Medical Society consulted with the Chairman on several occasions.

Respectfully submitted,

F. E. Reeder, M.D., *Chairman*
Wm. S. Jones, M.D.
W. Joe Smith, M.D.

●

ANNUAL REPORT OF CANCER CONTROL COMMITTEE, 1943-44

1. The Cancer Manual was published and distributed to members of the Michigan State Medical Society during the past year.

The Committee studied plans for future distribution of the Manual including the granting of permission to other state medical societies to use part or all of the material in the book. It also discussed the preliminary overtures made by a large medical publishing house to reprint the Cancer Manual to give it the wider distribution it merits.

The most sincere appreciation of the Cancer Control Committee is expressed to all the State Society members who contributed chapters for the Cancer Manual, and to the many others who aided with their active help and advice in the preparation of this work —a real contribution to Medicine.

2. A small pamphlet or brochure containing pertinent facts about cancer for distribution to nurses and social workers, in order that they may be adequately informed to properly advise those with whom they are in contact and who seek their opinion, was favorably discussed and plans for its formation were adopted.

3. The Cancer Control Committee recommends that county medical societies devote at least one program yearly to Cancer Control.

4. The Committee recommends that more emphasis be placed on cancer discussions in future conferences arranged by the MSMS Committee on Postgraduate Medical Education.

5. The Committee further recommends that the cancer-tumor clinics throughout the State be urged to form a coöperative group and have adjacent territorial group discussions and clinics at least once yearly, using their clinical material in conjunction with the clinical pathological discussion.

Respectfully submitted,

Wm. A. Hyland, M.D., *Chairman*
J. H. Cobane, M.D.
F. A. Coller, M.D.
C. E. DeMay, M.D.
C. K. Hasley, M.D.
Rollin H. Stevens, M.D.
C. V. Weller, M.D.

●

ANNUAL REPORT OF COMMITTEE ON INDUSTRIAL HEALTH, 1943-44

1. In an attempt to conserve manpower, gasoline, and rubber, the Committee on Industrial Health held only one meeting during the year, on February 3, 1944. The chief purpose of this meeting was to develop a program and to make plans for the Second Annual Industrial Health Conference. The Conference this year was held on April 6 and was jointly sponsored by the Committee on Industrial Health, MSMS and the Michigan Association of Industrial Physicians and Surgeons in coöperation with The Department of Postgraduate Medical Education, University of Michigan,

and the Wayne University College of Medicine. The meeting was attended by 231 individuals including physicians, nurses, personnel and employment men and a number of plant managers. The attendance was very gratifying, considering present conditions.

2. The Committee on Industrial Health sponsored four programs for county medical societies, including St. Clair County, Hillsdale County, Barry County and Eaton County. These four groups were addressed by Orlen J. Johnson, M.D. of the Council on Industrial Health of the American Medical Association.

3. The Committee on Industrial Health of the Wayne County Medical Society has developed an excellent health program for small industries, and copies of this program may be obtained from that County Society.

Respectfully submitted,
KENNETH E. MARKUSON, M.D., *Chairman*
H. H. GAY, M.D.
FRANK T. MCCORMICK, M.D.
C. K. HASLEY, M.D.
A. L. BROOKS, M.D.
HENRY COOK, M.D.
W. A. DAWSON, M.D.
W. B. HARM, M.D.
WM. P. CHESTER, M.D.
C. D. SELBY, M.D.

●

ANNUAL REPORT OF THE COMMITTEE ON NURSES TRAINING SCHOOLS, 1943-44

This committee has not met. In contacting the Michigan State Board of Registration for Nurses, the Chairman finds that they have done everything humanely possible to increase the supply. Likewise, they are so busily engaged in the excess work placed upon them that any discussion with them regarding changes we would like to see made, would be fruitless. They are definitely committed to the idea of raising the standards of nursing, which undoubtedly is a fine thing. Regarding the problem of distribution of these nurses, so that they may be equally distributed, they have no solution, and do not regard the establishment of Schools of Nursing in smaller communities as the proper answer.

Under these circumstances the Chairman did not deem it expedient to call a meeting of his committee for this year.

Respectfully submitted,
ELLERY A. OAKES, M.D., *Chairman*
A. L. ARNOLD, M.D.
C. G. CLIPPERT, M.D.
A. E. STICKLEY, M.D.
D. W. THORUP, M.D.

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ANNUAL REPORT OF LEGISLATIVE COMMITTEE, 1943-44

During the year 1944, your Legislative Committee held no meeting.

1. Two extra sessions of the Michigan Legislature were held, one in February and one in June. At the February session, bills covering appropriations to run the State Government for the fiscal year beginning July 1, 1944 were enacted, as well as Governor Kelly's juvenile delinquency and aid to veterans program. A total of 62 bills were introduced of which 5 were of special interest to Doctors of Medicine. These were discussed in detail in the April 1944 MSMS JOURNAL (page 280) and were designated as House Bills 8 and 9, and Senate Bills 1, 9, and 20.

At the June Session, only a proposal to validate the federal ballot for Michigan soldiers was considered.

2. Two matters were referred to the Legislative Committee by the 1943 MSMS House of Delegates:

(a) Hospital Licensing Act. The House of Delegates recommended that the Legislative Committee be instructed to explore the project, and to approve or disapprove such specific legislation as may be introduced.

The Legislative Committee wishes to report that, up to June 15, it had not been approached by any groups or individuals concerning the introduction of any such proposed legislation into the 1945 Legislature. If and when the proponents of a Hospital Licensing Act have completed their studies and developed a bill, the Legislative Committee will consider it carefully and follow the instructions of the House of Delegates.

(b) Taxes on Medical Homes. Copies of this Resolution, considered by the 1943 House of Delegates, were forwarded to all members of the Legislative Committee for their study and advice. A further statement on this matter will be presented to the 1944 House of Delegates in a supplemental report of your Legislative Committee.

3. Your Legislative Committee has coöperated with the American Medical Association in recommended contacts with members of the U. S. Congress on various proposals affecting Medicine and public health. The Committee wishes to report that, as in the past, it has received prompt and courteous consideration at the hands of U. S. Senators and Congressmen from Michigan.

Respectfully submitted,
HAROLD A. MILLER, M.D., *Chairman*
A. S. BRUNK, M.D.
V. M. MOORE, M.D.
R. G. COOK, M.D.
T. K. GRUBER, M.D.
S. L. LOUPEE, M.D.
G. L. MCCLELLAN, M.D.
H. L. MORRIS, M.D.
DEAN W. MYERS, M.D.
R. V. WALKER, M.D.
A. V. WENGER, M.D.
ELMER SCHNOOR, M.D.
JOHN J. WALCH, M.D.
L. G. CHRISTIAN, M.D., *Advisor*

●

ANNUAL REPORT OF CHILD WELFARE COMMITTEE, 1943-44

The Child Welfare Committee of the MSMS had one meeting to discuss two important problems.

I. The Grand Rapids Clinic problem with the following suggestions as to clinics in general.
   1. The present economic situation does not warrant an extension of pediatric clinics.
   2. The extension of pediatric clinics does not increase the availability of pediatric service. A pediatrician should be able to see patients more efficiently in his office than in a clinic.
   3. If specialist care is not desired—services could be better rendered by the family physician in his own office.

II. Postwar Pediatrics. In the discussion of these problems we hoped to stimulate further study and made the following observations pertinent thereto.
   1. Number of residencies in pediatrics will be inadequate.
   2. There will have to be extramural training programs.
      (a) Programs could be carried on in hospitals with visiting teaching personnel.
      (b) Preceptor systems could serve in many instances. This program would serve to inculcate in men the principles so necessary to maintain.
      (c) Preceptor system would also be "coronary" insurance for the older men.
   3. The necessity for enlarging the scope of pediatric practice—looking at the whole child in a broader sense with regard to those problems of medical significance that might be assumed by

lay groups—teachers, social worker, et al., was discussed.

The medical profession must be aware of the changing picture of the problems of medicine and the influence of new therapeutics on the patient.

The Committee also recommended that plans for postgraduate and refresher courses for doctors of medicine in all branches of medical practice, be developed and made ready for operation as soon as needed after the duration. During the discussion of this particular problem in the Preventive Medicine Committee meeting of May 25, 1944, it was suggested that the MSMS and other specialized groups maintain intimate contact with their members in the Armed Forces, in order to smooth out the readjustment period.

Respectfully submitted,
FRANK VAN SCHOICK, M.D. *Chairman*
R. M. KEMPTON, M.D., *Vice Chairman*
MOSES COOPERSTOCK, M.D.
CAMPBELL HARVEY, M.D.
CHAS. F. MCKHANN, M.D.
A. L. RICHARDSON, M.D.
L. J. SCHERMERHORN, M.D.
L. PAUL SONDA, M.D.

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ANNUAL REPORT OF VENEREAL DISEASE CONTROL COMMITTEE, 1943-44

Three meetings of the committee were held during the year: Detroit, September 22, 1943; Lansing, December 19, 1943, and Lansing, April 23, 1944.

Each meeting was preceded by a meeting of the Joint Committee on Venereal Disease Control of the State Bar Association and the Michigan State Medical Society. The activities of the joint committee are covered in a separate report.

The chief matters of new business discussed before our committee included the following:

Definition of infectious syphilis for the State Council of Health for the 1943 Regulations.

Oxidation and color changes in mapharsen.

Coöperation in the Postgraduate Program with one of our members joining the four-man team which made a tour through the Upper Peninsula for one week in May, 1944.

A request for quantitative Kahn tests was made to the laboratory to the State Health Department. We were advised that service could not be supplied at the present time because of the manpower shortage.

It was decided to revise the application blanks for special dispensation for marriage to include more instructions as to the type of information desired. These new blanks will be available in the near future.

Discussion of the prophylactic kit took place at each meeting without much further progress. The statement made in our last annual report to the effect that such kits would bear the statement "approved by the Michigan State Medical Society" was discussed before the Council and amended to read as follows: "This procedure carries the endorsement of the Venereal Disease Control Committee of the Michigan State Medical Society." It is indicated to await the results of investigations being carried out through the National Research Council on newer methods of prophylaxis to be recommended to the military services before pushing our proposed joint program with the druggists on chemical prophylaxis in civil life.

Respectfully submitted,
L. W. SHAFFER, M.D., *Chairman*
R. S. BREAKEY, M.D.
KENT ALCORN, M.D.
RUTH HERRICK, M.D.
HARTHER L. KEIM, M.D.
F. J. O'DONNELL, M.D.
R. S. RYAN, M.D.
WM. R. VIS, M.D.
N. W. GUTHRIE, M.D.

ANNUAL REPORT OF JOINT COMMITTEE ON V.D. CONTROL OF THE STATE BAR OF MICHIGAN AND THE MICHIGAN STATE MEDICAL SOCIETY, 1943-44

This committee met three times during the year: September 22, 1943, at the Statler Hotel, Detroit; December 19, 1943, at the Hotel Porter, Lansing; April 23, 1944, at the Hotel Olds, Lansing. Modification of the premarital law was discussed and a proposed amendment is being prepared for submission to the next meeting of the state legislature. Some provision for permitting the marriage of pregnant girls, who have venereal disease, is essential.

The sources of venereal disease in the army were studied in Wayne County by the subcommittee for that area, which found that an appreciable proportion, about 35 per cent of army infections thought to have been acquired in that area, gave as their place of encounter a beer garden, tavern or similar place of amusement. Similar figures were found for the entire state. It was decided that this was the proper place to attempt to reduce the incidence of venereal infection in the army in this area. A coöperative program was developed with the Michigan Liquor Control Commission in which the places of encounter reported to the State Health Department by the Army as having led to venereal infection were listed and supplied to the Liquor Control Commission. This commission wrote letters to the named taverns advising that they had been named as sources of venereal infections and that they were under surveillance. One place has had its liquor license revoked. Many of the places have been investigated personally. This program has had a beneficial effect by inducing tavern owners to discourage the patronage of unaccompanied females and it has made the tavern owners more willing to coöperate with health department investigators who are trying to find the girls who have been named as sources or contacts of venereal infection.

Juvenile delinquency was studied from the point of view of venereal disease and statistics were submitted showing that the proportion of all venereal infections reported as occurring in persons of teen-ages has increased during recent years.

Respectfully submitted,
N. W. GUTHRIE, M.D., *Chairman*
HARTHER L. KEIM, M.D.
L. W. SHAFFER, M.D.
R. S. BREAKEY, M.D.

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YOU AND YOUR BUSINESS

DETROIT MEDICAL CENTER

The Detroit Board of Education has approved a recommendation that the Corporation Council proceed with the condemnation of a site for the first unit of the Wayne University Medical Science Center.

The area includes the two blocks lying between Farnsworth and Theodore and running from Beaubien to Hastings, as well as a third block between Frederick, St. Antoine, Farnsworth and Beaubien. This will be the site of the Wayne University-County Hospital. None of the buildings in the condemned area will be demolished or the tenants removed until the war is ended, or such earlier time as the housing situation is eased.

MEDICINE OR SOCIALIZED MEDICINE

Medicine has to its credit a long list of discoveries and inventions which have to do with the most vital interests of humanity. With few exceptions these discoveries and inventions have come through individual effort. If they had been protected by patents, capitalized, commercialized, and paid for in proportion to their relative value, physicians and their families would now be in possession of much of the world's wealth. The members of the medical profession have preferred to say "This will prevent or cure disease; this will relieve suffering; this will save life; this is good for humanity and must be made available to all."—Lewis J. Moorman, J. Oklahoma State M. A., April, 1944.

AMERICAN HOSPITAL ASSOCIATION NAMES TWO NEW COUNCIL SECRETARIES

In keeping with its policy of research and service for members and to facilitate a more complete understanding of the complexities of health maintenance, the American Hospital Association announces the appointment of two new council secretaries.

Dr. Hugo V. Hullerman will be secretary of the Council on Professional Practice which coördinates matters of a professional nature in hospitals. Its scope covers affairs dealing with *medical service,* nursing, dietetics, social service, *x-ray, physical therapy* and related subjects.

Until his resignation to assume his new duties with the American Hospital Association, Dr. Hullerman was chief of the division of maternal and child hygiene of the Illinois department of health at Springfield. A graduate of the University of Minnesota medical school, Dr. Hullerman received a master of science degree in public health at the University of Michigan in 1938.

Hazen Dick is the newly appointed secretary of the association's Council on Administrative Practice. This council correlates for association members information of such general administrative fields as hospital economics, admission and collection procedure, personnel relations, accounting, and similar management responsibilities. Mr. Dick has been administrator of both the Louisville General Hospital and Waverly Hills Sanatorium in Kentucky.

NATIONAL FOUNDATION FOR THE CARE OF ADVANCED CANCER PATIENTS

Frank E. Adair, M.D., and four others organized the National Foundation for the Care of Advanced Cancer Patients. A sponsoring committee of sixty has been formed. The organization followed a study of conditions now prevailing where the indigent cancer patients are comparatively well provided for, but suitable provision is needed for the advanced cancer patients of moderate means. In some cases the report says the cost of the care of advanced cancer patients is prohibitive.

It is planned to make this proposal national in scope.

SHORTAGE OF PHYSICIANS

The physician shortage is purely a wartime situation. As the military forces increased the number of doctors necessary to meet the needs of the expanded army and navy services rose to over fifty thousand. Where there was one doctor for each 800 population there is now one for about 1,200, and the younger and more energetic have been taken into the armed forces, leaving the number of effective doctors much less than one to 1,200.

The nation's civilian physicians are doing all in their power to maintain during wartime the high level of medical care our nation enjoyed during peacetimes. The Office of War Information made a survey of the doctor shortage, and said "luxury medicine is out for the duration. Doctors will have to restrict their attention to those actually in need of them, and *patients must no longer insist on one particular favorite physician.*"

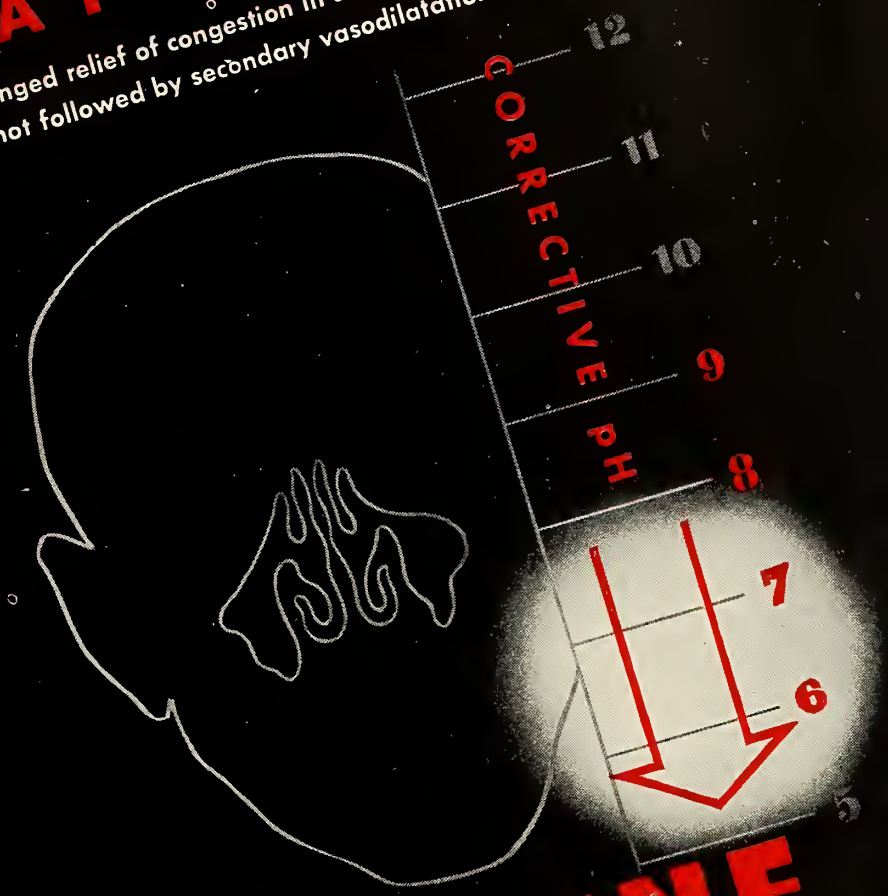
This agency found that those doctors left on the home front are not only working harder, but are actually working themselves to exhaustion.

The OWI offers some suggestions for the public to help out in the emergency, but it cannot avoid an ingenious hint leading to state medicine, as witness the italics, which are ours. (Editor)

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Prolonged relief of congestion in allergic rhinitis
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SALMONELLA PANAMA

The recent high incidence of meningitis of the newborn in Battle Creek and vicinity has been found to be due to Salmonella panama, a bacillus belonging to the enteric group and closely related to the typhoid bacillus.

Salmonella panama which, in older children and adults, generally causes a moderate gastro-enteritis, may invade the blood stream in the very young and result in meningitis with a high fatality rate.

An outbreak of this infection in hospital nurseries can be brought under control by the adoption of a technique similar to that used for the control of typhoid and other intestinal infections.

A number of carriers of Salmonella panama have been discovered among adults, a very significant fact. At present all known carriers are being given the same supervision by local full-time health departments as are typhoid carriers.

The Calhoun County Medical Society has appointed Doctors Schelm, Melges, LaPorte, Finch, Robins and Hoyt as a committee to work coöperatively with the City, County and State Health Departments to determine the original source of the outbreak.

Members of the Motor Corps of the local Red Cross are assisting by making home calls on contacts to obtain histories and stool specimens. At this time over sixty carriers have been identified among apparently healthy individuals.

Since Salmonella panama is spread in the same manner as typhoid, special attention is being paid to water and milk supplies, sewage disposal and sanitation in general. It has come to the attention of the Michigan Department of Health that many communities use sludge that has not been heat dried from their local sewage disposal plants for garden fertilizer. Although we have no positive proof, it is possible that this practice may be a factor in spreading this infection.

PINE CREST SANATORIUM

The State Sanatorium Commission has taken title to Pine Crest Santorium, Oshtemo, following authorization by the legislature. It will be known as the Pine Crest State Sanatorium. Dr. A. D. Calomeni, assistant director of the bureau of tuberculosis control, Michigan Department of Health, has been given temporary leave to direct this institution.

V-D RAPID TREATMENT

The Michigan Department of Health Rapid Treatment Center in Ann Arbor is scheduled to open in June. Any person with infectious syphilis or gonorrhea will be eligible for admission to this 150-bed center. Dr. Nelson Ryan has been assigned to the Michigan Department of Health by the U. S. Public Health Service to have charge of this Michigan center. Requests for admission must be made through the local health officials to Dr. Ryan.

PENICILLIN DISTRIBUTION

The Office of Civilian Penicillin Distribution has announced that beginning in May, 100 million Oxford units of penicillin will be available each month for Michigan hospitals. This will include all state hospitals, prisons, boys vocational school, girls training school and the schools for the blind and deaf. Purchasing will be done through the Michigan Department of Health and the purchasing division of the state administrative board.

CLASSIFIED ADVERTISING

SHERWOOD COUNTRY SCHOOL.—For resident children 3-13. 60-acre estate in beautiful Bloomfield Hills, 18 miles North of Detroit. Write: Dr. Katherine B. Greene, Ph.D., Director Sherwood School, Bloomfield Hills, Michigan.

FOR RENT—Office with established practice, nothing to buy; all equipment furnished, contact Frank A. Ware, M.D., 3519 Fenton Road, Flint, Michigan.

FOR SALE—Fisher X-ray apparatus Model 60-88 and complete accessories. Price $1,500.00. Contact Frank A. Ware, M.D., 3519 Fenton Road, Flint, Michigan.



COSMETIC *HAY FEVER?*

Prescribe UNSCENTED AR-EX Cosmetics

Recent clinical tests showed many cases of cosmetic sensitivity, but not a single one to UNSCENTED AR-EX Cosmetics. For allergic patients, prescribe UNSCENTED AR-EX Cosmetics—free from all known irritants and allergens. SEND FOR FREE FORMULARY.



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A Radio Program of Interest to All Physicians . . .

"THE DOCTOR FIGHTS"

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HERE is a Report to the Nation on the wide-spread activities of America's doctors in a world at war, not only on the battlefronts, but on the home front as well. Documentary histories of medical heroism, carefully authenticated and ethically presented, should prove of interest to every physician, military or civilian. The comments or suggestions of the profession are welcomed.

Tuesday Evenings
COLUMBIA BROADCASTING SYSTEM
9:30 E. W. T.—8:30 C. W. T.

SCHENLEY LABORATORIES, INC. · *Producers of* **PENICILLIN** *Schenley*
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LOOKING AHEAD

Another year of auxiliary activities, Red Cross work, War Loan drives, aid to the war effort and increased household tasks is coming to an end. We can look back with pride to our accomplishments during the past year, but we cannot slacken our efforts. Rather, they must be increased so that we will do our share to hasten the day of victory and peace.

Too much credit cannot be given your president, Mary Walch, and her untiring committee chairmen for the inspiration and guidance they have given each county auxiliary this last year. That your president-elect and the new committee chairmen may make their plans for the coming year, I should like to ask the county presidents for 1944-1945 to:

1. Read the Handbook given each county auxiliary September 1943.

2. Read the Bulletin (official publication of the Woman's Auxiliary to the AMA).

3. Read the pages devoted to auxiliary activities in the journals of the MSMS and the AMA.

4. Talk with auxiliary members about the Radio-Speech contest, Student Loan Fund, legislative activities and the Cadet Nurse Corps.

5. *Write Me.* I shall be glad to answer any question that I can and will appreciate any suggestions about improving the past methods of handling these projects or the adoption of new projects.

I wish to thank the president and officers for their unusual coöperation in keeping me informed of all auxiliary activities this year. With this help, and with the continued effort and coöperation of each Auxiliary member, 1944-1945 should be another successful year in the history of the Auxiliary.

Lela W. French, *President-elect*

Ingham County

Past presidents of the Auxiliary to the Ingham County Medical Society were honored at a tea given for members and guests recently in the home of the president, Mrs. T. I. Bauer, East Lansing. Albert Christ-Janer of Michigan State College art department gave a scholarly lecture, "Understanding the Arts," and exhibited and analyzed lithographs by John A. de Martelly and Charles Pollock, both of the college art department.

Mrs. Bauer presided. Mrs. Guy Kiefer, first president and later honorary president of the State Auxiliary, spoke on the importance of the work of medical auxiliaries and described the organization of the State Auxiliary.

Mrs. L. M. Folkers introduced Mr. Christ-Janer, who described the power of comprehension of art as a measure of one's wisdom, sensibilities, and intellectual vitality, requiring the education of the whole man in development of these powers.

Dr. Gene Cope and Mrs. Carleton Dean presided at the tea table.

Kent County

The December meeting of the Women's Auxiliary to the Kent County Medical Society was an outstanding one, thanks to the efforts of Mrs. William A. Hyland, who opened her lovely home for the occasion. Mrs. Ward Ferguson presided at a short business meeting, following which a social hour was enjoyed playing bridge and visiting. A delicious buffet supper climaxed a most pleasant evening.

The January meeting was held at the Browning Hotel. Three war information movies of current interest were shown: "Action at Tarawa," "News Parade of 1943" and "Know Your Enemy, Japan." This program was arranged by Mrs. Guy U. De Boer and Mrs. Martin Batts. Mrs. W. J. Butler and Mrs. Wm. A. Hyland represented the Auxiliary at the School of Information at the Presidents and Secretaries Conference of Michigan State Medical Society in Detroit, January 30.

The February meeting was an exceptionally interesting one. Mrs. William L. Rogers, nutrition chairman, presented a radio skit, "Food for Victory." She was assisted by Mrs. Frank M. Burroughs, Mrs. Margaret Anderson, and Miss Jeanne Houghton. They stressed the fact that food is an important weapon in bringing ultimate victory—that we must feed the civilians, the armed forces, the fighting allies and the people freed from Axis domination. The farmer and the Victory gardeners play an important role in the war effort, and we must preserve and conserve their products.

On March 8 Mrs. Martin Batts directed a one-act comedy, "Nominating Nightmares," which was presented by members of the Auxiliary. This comedy was a take-off on medical auxiliaries, and depicted in a very humorous manner all the difficulties which arise in such an organization.

Wayne County

Mrs. T. Grover Amos and Mrs. Charles J. Barone of the Women's Auxiliary of the Wayne County Mediacl Society presented E. L. Steiner, director of the blood donor service, and Mrs. E. C. Baumgarten, volunteer registered nurse, with a certificate of title to a station wagon for the blood bank. Funds for the purchase of the wagon were raised by the Auxiliary.



Facts for the patient inquiring about the

SAFETY

OF INTERNAL MENSTRUAL PROTECTION

Tampax menstrual tampons are more than merely *adequate* for catamenial protection...they possess a wide margin of safety, particularly on prolonged use.

Careful and extended research by authorities in different parts of the country—involving studies on bacterial flora, hydrogen ion concentration, vaginal mucosal biopsies, glycogen determinations and gross examinations in hundreds of cases—has failed to reveal any untoward results from the regular use of this form of menstrual hygiene.

For instance, one investigator[1] reports, "By exact research in 218 women who wore tampons regularly during their menstruation for one year and over, no production of irritation or discharge, vaginitis or cervicitis was found."

Another[2] states that, in 110 subjects using tampons throughout each period for a minimum of one year to a maximum of two years, "there was no evidence of any irritation of the cervix or vagina by the tampon."

A third clinician[3] (with a series of 21 subjects) writes that "no evidence was observed of any infection carried by the tampons."

Finally, the general consensus would seem to indicate that intravaginal menstrual protection will not cause blocking of the flow or cramps—rather that "tampons actually acted as a wick to draw away the blood from the cervix."[1]

Thus, Tampax can be soundly recommended to patients of menstruating age—on the basis that "the evidence is conclusive that the tampon method of menstrual hygiene is safe, comfortable and not prejudicial to health."[4]

(1) West. J. Surg., Obst. & Gyn., 51:150, 1943. (2) Am. J. Obst. & Gyn., 46:259, 1943. (3) Clin. Med. & Surg., 46:327, 1939. (4) Med. Rec., 155:316, 1942.

TAMPAX *accepted for advertising by the Journal of the American Medical Association*

TAMPAX INCORPORATED
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Please send me a professional supply of the three absorbencies of Tampax.

NAME_____

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Say you saw it in the Journal of the Michigan State Medical Society

CORRESPONDENCE

Mutual Benefit Health and Accident Assn. of Omaha
Omaha, Nebraska

Gentlemen:

Recently we received a letter from the Wayne County Medical Society, 4421 Woodward at Canfield, Detroit, one of our component societies, which contained the following paragraph:

"A. H. Lange, M.D., Chairman of the Insurance Studies Committee of the Wayne County Medical Society, and this office have been telephoned by several members in the last week who report that representatives of the Mutual Benefit Health & Accident Association of Omaha in their solicitations are creating the impression that they have a special group policy approved by the Michigan State Medical Society. The advertisement that appeared in the April issue of your Journal is an essential part of this alleged misrepresentation. Inasmuch as you state that your Council has not approved any particular insurance company or policy but feel this is a prerogative of the local societies, and also, inasmuch as the W.C.M.S has a special group policy approved by the Council of this organization, written by the Continental Casualty Company of Chicago, the contacts being made by the representatives of the Mutual Benefit Company are leading to considerable confusion and thereby resulting in a waste of very valuable time on the part of busy practitioners in this area.

"We do not wish to give the impression in this letter that we are in any way opposed to the representatives of any insurance company in the world calling upon and attempting to sell the individual members of this Society, but we are interested in stopping if it does exist, any injurious misrepresentation."

This communication from the Wayne County Medical Society was presented to the Executive Committee of the Council of the Michigan State Medical Society at its May 24 meeting, and thoroughly discussed.

The Executive Committee of the Council instructed that a letter be dispatched to you containing the above information from the Wayne County Medical Society, and further stating that the Michigan State Medical Society has not approved the policy of any insurance company, which approval or disapproval is the prerogative of the county medical societies; only the advertising of the Mutual Benefit Health & Accident Association of Omaha has been accepted for the MSMS Journal.

The Executive Committee of the Council would appreciate your taking whatever steps you deem advisable to eliminate any misunderstandings among members of the Wayne County Medical Society that may have resulted due to statements allegedly made by your representatives, either intentionally or otherwise, to the effect that the Michigan State Medical Society has approved your health and accident insurance policy.

We appreciate your coöperation in this matter and your early reply to transmit to the Insurance Studies Committee of the Wayne County Medical Society.

Yours very truly,
L. Fernald Foster, M.D.
June 3, 1944. *Secretary.*

Dr. L. Fernald Foster, Secretary,
Michigan State Medical Society,
2020 Olds Tower,
Lansing, 8, Michigan.

Dear Doctor:

The fair and courteous way in which you called attention to the situation in Wayne County with reference to some solicitation attributed to representatives of our Association is deeply appreciated, and we assure you of our earnest coöperation toward the end that our representatives may continue their enrollments strictly on the merits of our proposition without creating or leaving any erroneous impression as to approval by the State Society.

We are fortunate in having in Michigan a state manager of the highest ethics and integrity, and so are passing your letter along to Manager E. B. Brink who can be depended on to put back into the proper channels any representative who might have gone too far in his enthusiasm for the product that he has been offering.

Our Association is headed by Doctors of Medicine and our coöperation with the physicians and medical societies all over the country has been so splendid that we do not want anything to occur anywhere which would in any way jeopardize those fine relations which we have enjoyed for so many years.

Yours very truly,
Mutual Benefit Health & Accident Assn.
(Signed) S. C. Carroll
June 6, 1944 *Vice President*

To the Medical Profession of Michigan:

Directed by the Army Air Forces, of which it is an auxiliary, the Civil Air Patrol throughout the country, beginning July 1, adds to its duties by undertaking the physical examination of cadets from the age of 15 through 17; the purpose is to determine in advance the state of health of the nation's teen-agers and thereby to advise or assist in correcting ills, so that these youngsters will be able to serve their country on reaching the inductible age of 18.

To accomplish this tremendous task it is necessary to obtain the assistance of all physicians.

Therefore, it is incumbent on me to urge physicians to contact CAP units in their localities so that arrangements may be made for a large part of these examinations. Forms for the examinations are being printed and will be distributed within a month, with full instructions as to the use.

It is also here pointed out that there remain vacancies for medical officers in several squadrons in this state. To fill these posts physicians who find it at all possible to do so are asked to make application for membership to the squadrons most convenient to their locality. For medical officers, as well as many others in Civil Air Patrol, flying experience is not mandatory.

Captain J. A. Nowicki, M.D.,
Detroit, Medical Officer, Mich.
June 1, 1944 Wing 63, C.P.A.

Summer Heat . . .
Phagocytosis . . .
Protein Need . . .

The efficacy of phagocytosis is definitely linked to adequate protein intake. As environmental temperature rises, the diet-percentage of protein apparently must rise proportionately, to maintain phagocytosis at optimum.* Meat is a rich source of proteins, and its proteins are of highest biologic quality, the RIGHT KIND for every bodily need, including phagocyte activity.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

* Commenting editorially on the work of Mills and Cottingham (J. Immunol. 47:503 [Dec.] 1943), THE JOURNAL states: "They found that after five and one-half weeks maintenance at 68 F. rats showed a maximum phagocytic activity on diets containing 18 per cent of protein. There was a definite decrease in phagocytic activity with an increase or decrease from this level. In rats maintained at 90+F. the phagocytic optimum diet was 36 per cent of protein. Thus adequate protein intake would seem to be fully as important as adequate vitamin intake to maintain optimal phagocytic activity (resistance to microbic infections). The immunologic optimum protein intake is higher in the tropics than in temperate climates. . . . This demonstration of important variations in phagocytic functions is a pioneer contribution to basic immunologic theory and may have wide clinical implications." (J.A.M.A. 124:1203 [April 22] 1944.)

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Say you saw it in the Journal of the Michigan State Medical Society

COUNTY AND PERSONAL ACTIVITIES

It is estimated that 22.7 per cent of the total national income, or $33.6 billion, was saved in 1943 by the people of the United States.

* * *

"*Since Pearl Harbor,* a decline of approximately 10 per cent has taken place in the total number of small business establishments in the United States."

—Committee for Economic Development.

* * *

O. W. Mitton, M.D., of East Tawas, G. F. Moore, M.D. of Mt. Clemens, and Russell H. Strange, M.D. of Mt. Pleasant attended the Refraction Clinic and the Postgraduate Course given by Ralph Woods, M.D. at Janesville, Wisconsin, recently.

* * *

To many a war-weary and travel-worn veteran, social security means the opportunity to settle down in a home of his own. Will his plans to meet payments on a home take account of unexpectedly high social insurance deductions from earnings?

* * *

Postal Zone.—Doctor, please send your postal zone to the Record Department of the Michigan State Medical Society, 2020 Olds Tower, Lansing 8, Michigan, to facilitate mailings from the State Society. Many thanks.

* * *

The American Congress of Physical Therapy will hold its 23d Session at the Statler Hotel, Cleveland, Ohio, September 6, 7, 8 and 9. For information and program write the American Congress, 30 North Michigan Avenue, Chicago 2, Illinois.

* * *

The Gratiot-Isabella-Clare Medical Society celebrated its 300th meeting on May 25 with a meeting in St. Louis, Michigan. Three charter members of the Society, organized forty-two years ago, were present: B. C. Hall, M.D. of Pompeii, W. M. Drake, M.D. of Breckenridge, and H. F. Kilborn, M.D. of Ithaca.

* * *

Medical service plans are available in conjunction with Hospital Service plans throughout the states of California, Colorado, Delaware, Massachusetts, Michigan, New Jersey, North Carolina and Pennsylvania. In addition, regional plans operate with headquarters in Buffalo, Utica, and New York City.

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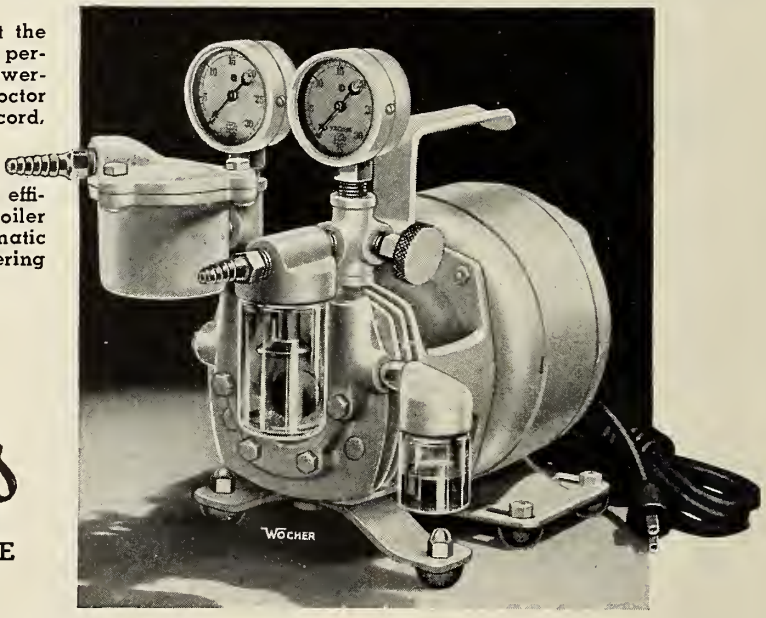
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The Michigan Pathological Society held its regular bi-monthly meeting on May 27, 1944, at Eloise Hospital. The scientific session was devoted to a seminar on "Lesions of the Mouth" and was conducted by Dr. D. A. Kerr of the Department of Pathology, University of Michigan. Forty-seven members and guests were present.

* * *

The Toledo (Ohio) Academy of Medicine plans a Memorial Building as a testimonial to the physicians of Toledo who served with the Armed Forces of the United States in World War I and World War II. An assessment of $300 per member for a new memorial building, or $150 per member for remodeling the present home of the Academy of Medicine, is being presented to the membership for decision.

* * *

"*The legal profession* is going to be next on the list," stated Charles Humphrey of Ironwood, President of the State Bar of Michigan, in addressing the Genesee County Bar Association, May 17, on the subject of "Socialized Medicine." Mr. Humphrey warned that if the Wagner-Murray-Dingell Bill becomes law, "it will be just another short step to socialization of all our national activities."

* * *

Taxes.—The date for final adjustments has been changed. You can now make final adjustments on January 15, 1945, instead of December 15, 1944. This eliminates the guesswork of last year in filing on December 15. Also you may, if you so desire, file your final return on January 15 instead of March 15, 1945. No penalty will be imposed for any underestimate that results from the new law.

* * *

The Baruch Committee on Physical Medicine has appointed a Scientific Advisory Committee of which Frank H. Krusen, M.D., Rochester, Minnesota, is Chairman, and a Committee on War and Postwar Physical Rehabilitation and Reconditioning, of which Dr. Ernest J. Jaqua, of Eugene, Oregon, former President of Scripps College, will be Educational Director.

The Baruch committee is located at 597 Madison Avenue, New York City.

* * *

Societies meeting coincident with the MSMS Annual Session in Grand Rapids:

1. *Michigan Pathologic Society*—Wednesday, September 27, beginning with the meeting of the Pathology Section at 12:00 noon, Grill Room, Pantlind Hotel, Grand Rapids.
2. *Michigan Chapter of the American College of Chest Physicians*—Thursday, September 28, Pantlind Hotel, Grand Rapids.

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Mastitis, nodules, nursing, prenatal, prolapsed atrophic breasts, ptosis, stasis in breast tissues, amputation.

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Lumbosacral sprain also relieved by a Spencer. Each Spencer is designed individually for the one who is to wear it.

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*Literature on Request

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As a part-owner of the MSMS JOURNAL, your personal interest is served every time you clip an advertiser's coupon.

* * *

Thirty days' notice.—In connection with requests for Emeritus and Retired Membership, the MSMS By-Laws in Chapter I, Section 8, state: "Transfers shall be by election in the House of Delegates. Requests for transfers shall be accompanied by certification by the secretary of the State Society, as to years of practice and years of membership in good standing. The County Society of such members shall make request for certification, in writing, to the Secretary of the State Society thirty days in advance of an annual session."

* * *

"*Strikes* have been so numerous throughout the United States since Pearl Harbor, all of which have involved either directly or indirectly the production of material and supplies sorely needed by the service branches of the Government, that it can readily be assumed that subversive activities are on such a huge scale that they are undermining our constitutional form of government, the free enterprise system, the right to work, enjoy the unmolested sanctity of our homes, and a suspension of the seizure of property without due process of law."

—HARVEY CAMPBELL, Detroit.

* * *

Too Little and Too Late.—It is obviously necessary to reorganize the American Medical Association to make it more responsive to the wishes and demands of the rank and file membership. There are a great many things that never get done until too late to be of use. Too little and too late has too often been the rule in organized medicine. One striking example is the action taken, or lack of action we should say, in the instance of the material benefit for servicemen foisted upon the profession without warning or knowledge before hand. Maybe nothing could have averted this Federal program but something might have been done to change it into a more suitable form than it now is.—*Bulletin,* Oakland County Medical Society, June, 1944.

* * *

Floyd E. Armstrong, Professor of Economics and Finance, Massachusetts Institute of Technology, Cambridge, has addressed additional numbers of Michigan groups and societies on "What Price Security" as follows:

May 13, Annual Convention of Junior Chamber of

Say you saw it in the Journal of the Michigan State Medical Society

Commerce, Grand Rapids; May 17, Junior Industrial Club of Lansing, Lansing; May 18, Public Meeting arranged by the Manistee Woman's Auxiliary, Manistee; June 5, Joint Meeting of service clubs of St. Joseph and Benton Harbor, St. Joseph; June 12, public meeting arranged by Rotary Club, Durand; June 13, public meeting arranged by Rotary Club, Marlette; June 20, joint meeting of all service clubs and wives, Kalamazoo; June 22, Rotary Club, Pontiac.

Autumn meetings scheduled include a talk at the Annual Session of the MSMS Woman's Auxiliary, in Grand Rapids, September 28; a public meeting arranged by the St. Clair County Medical Society in Port Huron on October 10.

* * *

"*After some figuring* I have found the white collar girl is behind the well-known eight-ball. I am a stenographer working six days a week at $30.00 a week. After my deductions as follows:

20%	Income Tax	$6.00
5%	Victory Tax	1.50
3%	Social Security	.90
10%	Bonds	3.00
		$11.40

I receive the total sum of $18.60. Of course, I realize the 10 per cent bonds are mine.

"Due to the fact that I have an apartment for my mother and me, I have a cleaning girl one day every two weeks at $5 and carfare, which leaves my actual salary per week $18.60, less $2.60, $16.00!

"Now, the cleaning girl works six days a week for different parties, thus making $30 a week, less no tax or other deductions. She pays no income, victory or social security because no one reports her for fear she'll quit. Also her husband works for a nice sum in a defense plant and claims deductions for a married man. This wife has 'no income.'

"Methinks I am one ——— Dumb Steno."

* * *

Michigan physicians on the Program of the American Medical Association Scientific Assembly, held in Chicago June 12 to 16, included: Frederick A. Coller, M.D., Norman F. Miller, M.D., Reed M. Nesbit, M.D., C. L. Pannabecker, M.D., Thomas Francis, Jr., M.D., Udo J. Wile, M.D., L. E. Himler, M.D., R. W. Waggoner, M.D., H. M. Pollard, M.D. and A. C. Curtis, M.D. of Ann Arbor; J. M. Robb, M.D., Major S. J. Nichamin, M.C., AUS, E. S. Gurdjian, M.D., Major John E. Webster, M.C., AUS, W. E. Stone, M.D., C. D. Selby, M.D., H. P. Doub, M.D., Edward G. Martin, M.D., John G. Mateer, M.D. and Frank W. Hartman, M.D. of Detroit; and Pearl Hendrick, M.D., Grand Rapids.

Michigan men participating in the Scientific Exhibit of the AMA included: George J. Curry, M.D., Flint; C. H. Snyder, M.D., Grand Rapids; R. D. McClure, M.D., C. R. Lam, M.D. and John W. Hirshfield, M.D., Detroit; Max R. Burnell, M.D., Flint; John W. Towey, M.D., Powers; Brock E. Brush, M.D., Detroit; Henry Turkel, M.D. and Frank H. Bethell, M.D., Ann Arbor; S. E. Gould, M.D., Eloise; R. W. Wag-

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goner, M.D., Ann Arbor; E. S. Gurdjian, M.D., Major John E. Webster, MC, AUS, and D. J. Leithauser, M.D., Detroit.

* * *

Meeting of Michigan Medical Service Membership

The fifth annual meeting of the membership of Michigan Medical Service will be held in the Ballroom of the Pantlind Hotel, Grand Rapids on Tuesday, September 26, 2:00 P.M. The membership is composed of all duly accredited members of the MSMS House of Delegates plus the members of the Board of Directors of Michigan Medical Service.

* * *

Biddle Lecturer of 1944

Preston Bradley, LL.D., D.D., Chicago, has been selected by President C. R. Keyport, M.D., to be the Biddle orator of the Michigan State Medical Society for 1944. Dr. Bradley will speak at the General Assembly of Wednesday, September 27, 8:30 P.M., Ballroom, Pantlind Hotel, Grand Rapids. The public is invited to attend.

* * *

Council and Committee Meetings

1. Preventive Medicine Committee, Statler Hotel, Detroit—May 25
2. Special Committee on Education, Michigan Union, Ann Arbor—June 1
3. Special Committee on EMIC Program, Statler Hotel, Detroit—June 8
4. Special Committee on EMIC Program, State Laboratory, Lansing—June 22
5. Executive Committee of The Council, Olds Hotel, Lansing—June 22
6. The Council, Mackinac Island—July 21-22

* * *

The Doctor's Dispute

It would, of course, be presumptuous for a layman to pass on the merits of claims of doctors of medicine and osteopaths as to their relative efficiency in the treatment and cure of human ills.

But so far as their clash over the application of the osteopaths for permission to practice in our General Hospital is concerned, we have no hesitancy in siding with the members of the medical schools. And not necessarily because we are convinced their ministrations are the more beneficial, but because admission of their rivals would disorganize the service.

As we understand it, the regulars, doctors and nurses, are forbidden by the rules of their profession to collaborate with the newcomers. Their withdrawal, of course, would make the local hospital worthless to the community, or practically so. The city commission should negative any move to disturb the existing routine.

It will be time enough when the war is over and doctors more plentiful to agitate this question and settle it on its merits.

At the same time, it is not edifying to hear representatives of the medics threaten a walkout. Something like the CIO might have been guilty of when it was young and inexperienced.—*Bay City Times,* April 18, 1944.

What the People of Michigan Think of Medicine

A factual statement showing Medicine's faults and virtues, based on a survey now being made by the Michigan Health Council, will be presented to members of the Michigan State Medical Society at the annual session of 1944.

R. L. Novy, M.D., Detroit, representative of Michigan Medical Service on the Health Council, will be one of the guest speakers. An interpretation of the poll, which will be completed immediately preceding the annual session of the state society, will be given by John F. Hunt, executive of Foote, Cone and Belding, Chicago, which firm is conducting the survey.

This important session will be held in the ballroom of the Pantlind Hotel, Thursday, September 28, 1944, 8:30 P.M.

New MSMS Radio Hour

Beginning August 1, the Public Relations Committee of the State Society will sponsor two radio periods every week over the following Michigan stations:

WXYZ, Detroit
WBCK, Bay City
WJIM, Lansing
WSOO, Sault Ste. Marie
WOOD, Grand Rapids
WELL, Battle Creek
WIBM, Jackson
WHDF, Calumet
WFDF, Flint
WKTZ, Muskegon
WDBC, Escanaba
WDMJ, Marquette

These presentations will be dramatized sequences to depict the public benefits of present-type medical practice and its supplemental facilities (such as voluntary group medical service). The benefits of the time-tried American way of medical care will be contrasted to proposed forms of federal, bureaucratic, compulsory Medicine.

The program has been developed by the Advisory Committee on Radio composed of C. L. Candler, M.D., A. S. Brunk, M.D. and P. L. Ledwidge, M.D. of Detroit, and President C. R. Keyport, M.D. of Grayling, a committee named by Fred R. Reed, M.D., Three Rivers, Chairman of the Public Relations Committee.

Listen to the MSMS Radio Hour—(See page 623). President Keyport would like to know what you think of this new MSMS activity. Send him your comments to Grayling, Michigan.

* * *

U. S. Hires 13,000 More

The number of civilian government employes increased 13,000 during April, bringing the total on April 30 to 2,850,000—the highest since last July, the civil service commission reported today.—*Detroit Times*, June 8, 1944.

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In Memoriam

DIED IN MILITARY SERVICE

Lewis J. Geerlings of Fremont was born May 25, 1907 in Grand Rapids and was graduated from Rush Medical College in 1932. He served his internship at Presbyterian Hospital of Chicago and completed his work there in 1933. Before locating in Fremont, Doctor Geerlings was engaged in the practice of medicine in Stanton, Lansing, Oklahoma and Shelbyville, Illinois. He enlisted in the Medical Corps immediately after the Japanese attack on Pearl Harbor and reported for active duty on May 16, 1942. He trained at Geiger Field, Washington, for about five months, and was then sent to Randolph Field, Texas, for special training in psychiatry. In March, 1943, he left for North Africa. He was stationed at Pantelleria for several months and was assigned to Sicily following the invasion of the island. For several weeks he was stationed near Mt. Vesuvius in Italy and later returned to Sicily. He was sent to Corsica after a permanent base was established on the island several months ago. He was a flight surgeon and was killed in a plane accident on the Island of Corsica on May 10, 1944.

Frank P. Bohn of Newberry was born in 1866 in Indiana and was graduated from the Medical School of Indiana in 1890. After graduation, he began his medical practice at Seney. He walked 26 miles to treat his first patient. For years he traveled horseback, on snowshoes, by canoe and dog team, to minister to the sick and injured over a vast territory. Doctor Bohn lived in Newberry since 1898. He was elected to Emeritus Membership in the Michigan State Medical Society in 1940. In addition to his practice, he was president of a bank, director of a real estate company and had served three terms in Congress and two terms in the State Senate. During his service in Congress he sponsored a number of measures of particular benefit to Northern Michigan. Doctor Bohn died June 1, 1944.

Ervin D. Brooks of Kalamazoo was born at Dundee in 1854 and was graduated from the University of Michigan Medical School in 1885. Subsequently he studied eye, ear, nose and throat at the College of Chicago and the University of Vienna in 1896. In 1912 he received a law degree from the Chicago Law School. He opened his practice in Flushing where he remained until 1907, when he moved to Kalamazoo. Besides being a leader in his profession, he was interested in many civic affairs. He was elected to Emeritus Membership in the Michigan State Medical Society in 1938. Doctor Brooks died April 29, 1944.

William C. Hawken of Detroit was born in Rochester, November 12, 1901, and was graduated from the Detroit College of Medicine and Surgery in 1928. He was on the staff of Providence Hospital and was associated with Mt. Carmel, St. Mary's and Receiving hospitals. He was Senior Medical Examiner for the board of education and was an instructor in surgery at the Wayne College of Medicine. He died June 7, 1944.

Theodore F. Heavenrich of Port Huron was born in Detroit, May 31, 1874, and was graduated from the

Detroit College of Medicine in 1900. He served his internship at Harper Hospital. He then located in Port Huron to begin his practice as a physician and surgeon. During his career he was prominent in county and state medical circles, serving as president of the St. Clair County Medical Society in 1911, chairman of the Port Huron hospital staff and as vice-chairman of the executive board of the Michigan State Medical Society. He served as Councilor of the Seventh District of the Michigan State Medical Society, from June, 1927 to January, 1939. In addition to his work in the medical and surgical field, he spent much of his time in furthering the advancement of the medical profession. He was also chairman of the Port Huron NRA compliance board in 1932 and was chief surgeon of the old Detroit United Railways. He was physician and surgeon for the Port Huron Sulphite & Paper Co. and the Detroit Edison company. Doctor Heavenrich died May 5, 1944.

Harry W. Long of Escanaba was born July 29, 1878, at Frederickton, New Brunswick, and was graduated from Northwestern University Medical School in 1900. After graduation he located with his brother, C. H. Long, M.D., in Escanaba. He organized the Cottage Hospital and conducted that institution for several years. In 1914, Dr. Long went to Austria to take a course in eye, ear, nose and throat under eminent specialists in that country. He was in Austria when World War I broke out. He experienced great difficulty in escaping from Europe, but finally returned and was preparing to engage in practice as a specialist when America entered the war. He took his military training and was commissioned a captain in the Army Medical Corps. He received his honorary discharge June 30, 1919. He then took postgraduate work at Rush Medical College and later opened an office at Gary, Indiana. He returned to Escanaba in 1934 and remained there until the time of his death, May 30, 1944.

Edward J. Lynch of Detroit was borne April 8, 1885, in Jackson and was graduated from the Saint Louis University College of Medicine in 1913. Two years after graduation he served both as an intern and resident on the staff of Saint John's Hospital, Saint Louis, Missouri, and for two more additional years as resident on the staff of Mount Saint Rose Hospital, Saint Louis, Missouri. During the last World War he served as a first lieutenant in the Army Medical Corps. For a number of years he was in general practice and since 1933 had specialized in proctology. Doctor Lynch died April 18, 1944.

Charles A. Mooney of Ferndale was born June 1, 1889 in Clarion County, Pennsylvania, and was graduated from the University of Michigan Medical School in 1916. For the last twenty years Doctor Mooney has practiced in Ferndale; eight of these he served as city health officer. In World War I, he served overseas as a first lieutenant. He was chairman of the Oakland County Board of the Tuberculosis Sanitarium. Doctor Mooney died May 30, 1944.

Peter Arthur Scheurer of Manchester was born February 5, 1885 at Eureka and was graduated from the Detroit College of Medicine in 1908. Doctor Scheurer was on the staff of Mercy Hospital, Jackson, for more than twenty years. He was president of the Peoples Bank at Manchester and a member of the school board, the village council, and was active in many other civic organizations. He died June 16, 1944.

Clifford Caudy Young was born January 9, 1887 in Manhattan, Kansas, and received a Doctor of Public Health degree at the University of Michigan in 1924. He had served as Director of the Bureau of Laboratories of the Michigan Department of Health since 1919. The state of Michigan lost a brilliant public health officer who brought national recognition to the state when Doctor Young died on June 5, 1944. The Michigan Legislature on June 19, 1944, adopted a resolution to call the State Health Laboratories, "The Dr. C. C. Young Laboratories."

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MEDICINE—Two-Week Personal Course in Electrocardiography and Heart Disease starts August 7. Two-Week Course in Internal Medicine starts October 16.
GYNECOLOGY—Two-Week Intensive Course starts October 2. One-Month Personal Course starts August 7. One-Week Course in Vaginal Approach to Pelvic Surgery starts October 23.
OBSTETRICS—Two-Week Intensive Course starts October 16.
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Penicillin in Surgery

(Continued from Page 588)

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MSMS

MICHIGAN STATE BOARD OF REGISTRATION IN MEDICINE

The dates for the coming examinations of the Michigan State Board of Registration in Medicine are as follows:

Ann Arbor—Monday, Tuesday, Wednesday, July 24, 25, and 26, 1944.

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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

FEMALE ENDOCRINOLOGY. By Jacob Hoffman, A.B., M.D., Demonstrator in Gynecology, Jefferson Medical College; Pathologist in Gynecology, Jefferson Hospital; Formerly Research Fellow in Endocrinology and Director of the Endocrine Clinic, Gynecological Department, Jefferson Hospital, Philadelphia. 788 pages with 180 illustrations, including some in colors. Philadelphia and London: W. B. Saunders Company, 1944. Price $10.00

Doctor Hoffman has given us a real textbook of endocrinology, dealing with every phase of the subject and pointing out the relationship to gland and life function, sex characteristics, nutrition and weight. There are twenty-two chapters on the physiology of the many organs and functions, and the endocrine role in these functions such as the corpus lutem, the follicle, the "safe period," menstruation, uterine motility, and the placenta. The physiology of the breast, testes, anterior hypophysis, the posterior hypophysis, the thyroid gland, the suprarenals, et cetera is fully presented. The second part of the book discusses adolescence, the menorrheas, sterility, spontaneous habitual abortion, the climacteric, obesity, endocrinopathies, et cetera. The third part is devoted to laboratory aids, procedures, et cetera.

This book is well prepared, clearly and interestingly written, and should be a great aid to the practitioner in the field.

PRACTICAL MALARIA CONTROL. A handbook for Field-Workers. By Carl E. M. Gunther, M.D., B.S., D.T.M. (Sydney); Field Medical Officer, Bulolo Gold Dredging Limited. Territory of New Guinea. At present with the Australian Medical Corps. New York: Philosophical Library, 1944. Price $2.50.

A very practical, small handbook giving the facts and methods of malaria control, using every proposed plan from the elimination of the vectors to the control of the patients. Plans that have been found useful are given. This book is of especial use to us in Michigan just now, because malaria is again one of the diseases with which we must reckon. Treatment is also outlined, and the complications given.

SULFONAMIDE THERAPY IN MEDICAL PRACTICE. By Frederick C. Smith, M.D., M.Sc., (Med.) F.A.P.S. Editor of Philadelphia Medicine, the official organ of the Philadelphia County Medical Society, Editor, the Medical World, Lieut. Col., Medical Reserve, U. S. Army. Foreword by George Morris Piersol, B.S., M.D., Professor of Medicine, Graduate School of Medicine, of the University of Pennsylvania, Illustrated. Philadelphia: F. A. Davis Company, 1944. Price $5.00.

The sulfonamides have been one of the most important advances in the practice of medicine of the present century. There are many of them and each one has different uses. This book is timely. It gives the various drugs, their structural forms, and their uses. The diseases that respond to sulfonamide treatment are described, with the outline of treatment, dosage, precautions. Case reports are given. The uses in surgery, the various methods of administration and tabulations of results. This book puts in compact and usable form the world of material that has developed in the few years of this treatment. It will be valuable on our reading desks.

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ELIMINATION DIETS AND PATIENTS' ALLERGIES. A Handbook of Allergy. By Albert H. Rowe, M.D., Lecturer in Medicine, University of California Medical School, Second Edition, Thoroughly Revised. Philadelphia: Lea & Febiger, 1944. Price $3.50.

Elimination diets for the diagnosis and treatment of Allergies due to foods have been used for many years, and with great success in those cases which did not respond to skin tests, scratch test, et cetera. The theory of the diets is well given by the student who first suggested them. The relations of the various foods, their classification and the reasons for some puzzling allergic facts are given. Sample diets are given for the various types of conditions, and patients. The tests and studies in diagnosing allergy are given, with reasons and methods. The dietary treatment is especially interesting. To one doing allergy in any of its applications this book is essential.

THE ART AND SCIENCE OF NUTRITION. By Estelle E. Hawley, Ph.D., and Grace Carden, B.S., The University of Rochester School of Medicine and Dentistry, Strong Memorial and Rochester Municipal Hospitals. With 139 illustrations including 11 in color. St. Louis: The C. V. Mosby Company, 1944. Price $3.75.

The history of nutrition, the deficiencies, and studies in metabolism form the foundation of this book of 668 pages. The food elements, their values and place in body building is the prime theme. Weight control, diet in the various diseases, infant feeding occupy forty-eight chapters. The balance is devoted to choice, preparation and serving of foods, an outline of twenty teaching lessons. The appendix is a hundred and twenty pages of facts and various information of distinct



value to the teacher, the dietitian, and the doctor who must prescribe diets for his patients. The food habits of different classes of people are given as a guide to prescribing. Hundreds of foods are tabulated as to food composition.

The book should be on the desk of dietitians and doctors.

VIRUS DISEASES IN MAN, ANIMAL AND PLANT. By Gustav Seiffert. A survey and reports covering major research work done during the last decade. New York: Philosophical Library, 1944. Price $5.00.

This volume is published at the recommendation of the National Research Council, and gives a survey of the present status of virus investigation with special reference to the most recent literature, and especially the foreign literature. "By the term 'virus' are designated substances that can engender definite contageous diseases whose nature and character are not yet clearly known."

Viruses are invisible and filterable, but methods are available to make them visible and measureable. The study of the characteristics of virus, and the production of certain of them in crystalline form, natural and acquired immunity, protective inoculation and epidemiology take up about a third of the book. The diseases are discussed, classifying them under groups: variola, herpes, trachoma, et cetera. The book is very interesting reading, and judging from the list of diseases discussed it comes in the field of every practitioner.

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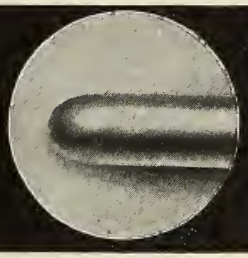
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A MANUAL OF PHYSICAL THERAPY. By Richard Kovacs, M.D., Professor of Physical Therapy, New York Polyclinic Medical School and Hospital: Attending Physical Therapist Manhattan State, Harlem Valley State, Columbus and West Side Hospitals, New York. Third edition, thoroughly revised, with 118 engravings. Philadelphia: Lea & Febiger, 1944. Price $3.25.

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THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY. By W. A. Newman Dorland, A.M., M.D., F.A.C.S., Lieut.-Colonel, M.R.C., U. S. Army; Member of the Committee on Nomenclature and Classification of Diseases of the American Medical Association; Editor of "American Pocket Medical Dictionary." With the collaboration of E. C. L. Miller, M.D., Medical College of Virginia. Twentieth Edition, Revised and Enlarged. 1668 pages with 885 illustrations, including 240 portraits. Flexible and Stiff Binding. Philadelphia and London: W. B. Saunders Company, 1944. Plain $7.00; Thumb-Indexed $7.50.

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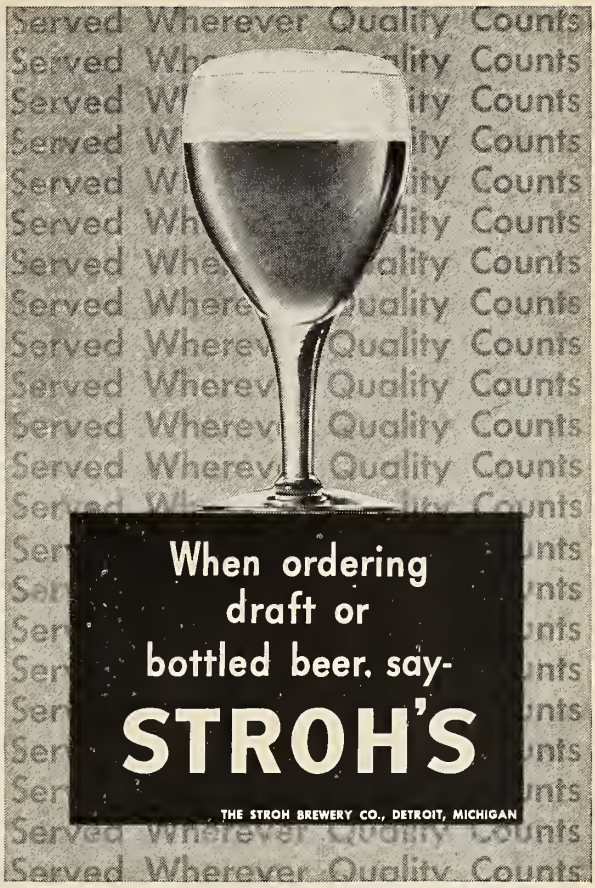
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Becker, Otto K., Co. 615
Bernheim Distilling Co. 546
Burroughs-Wellcome & Co. 531, 543

Camel Cigarettes 533
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Canada Dry Ginger Ale, Inc. 613
Central Laboratories, Detroit 624
Central Laboratory, Saginaw 623
Ciba Pharmaceutical Products 603
Insert, facing page 544
Classified Advertising 604
Clinical Laboratories 622
Coca-Cola Co. 620
Cook County Graduate School of Medicine 618

DeNike Sanitarium 622
Denver Chemical Manufacturing Co. 552

Ferguson-Droste-Ferguson Sanitarium 614

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Hack Shoe Co. 555
Harrower Laboratory, Inc. 619
Hartz, J. F., Co. 535
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Lilly, Eli, & Co. 556

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Mead Johnson & Co. ..... Back Cover
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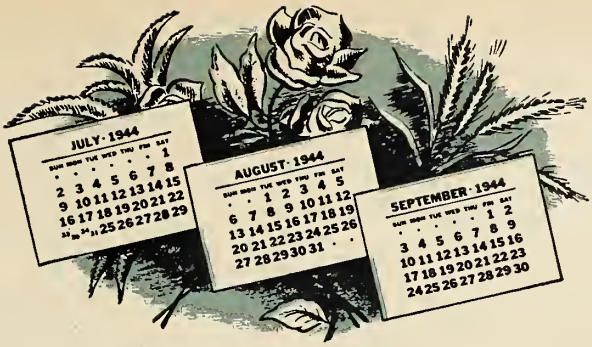
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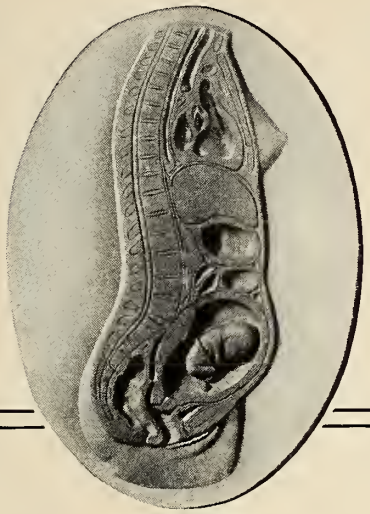
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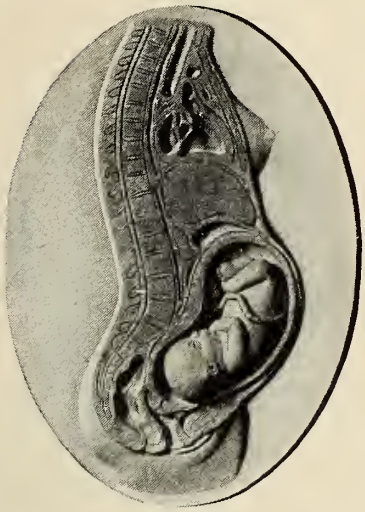
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ANATOMY OF PREGNANCY

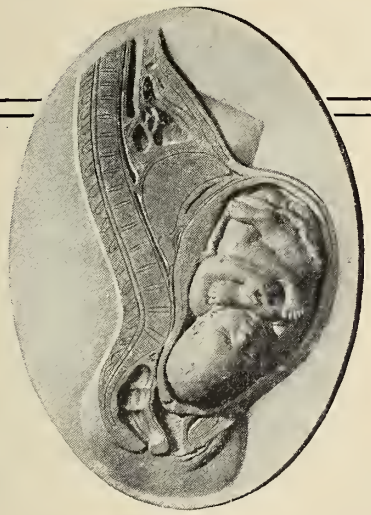
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4 Lunar Months—Abdominal protrusion beginning. Uterus becomes abdominal organ. Fundus 4 cm. below umbilicus. Approximate time of quickening. Normal visceral relationship. No appreciable change in body mechanics.

7 Lunar Months—Beginning tension on recti. Uterine fundus 5.5 cm. above umbilicus. Cephalic presentation determined. Visceral displacement (upward and lateral). Lumbar and dorsal curves increased. Relaxation of sacro-iliac and pubic joints.

10 Lunar Months—Overdistension of recti and diastasis are obvious. Fetus and placenta fully developed. Head engaging (L.O.P.). Marked visceral displacement (upward and lateral). Marked lumbar lordosis "pride of pregnancy." Relaxation of pelvic joints.



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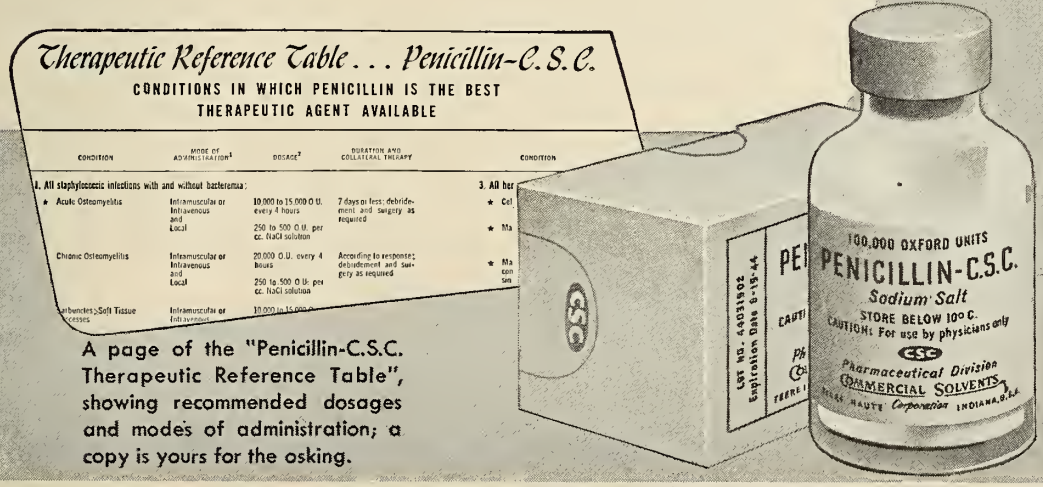
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POLITICAL MEDICINE

WAGNER-MURRAY-DINGELL OUTDONE

An initiative petition for an amendment to the Constitution of the State of Michigan has been filed as of June 16, 1944. Following are a few quotations from the petition. They will give an idea of the scope of the measure. *It could pass.*

PREAMBLE: "To create a Social Insurance Commission, to provide for social insurance benefits and contributions, and to empower the legislature to increase such contributions and to extend grants to agencies of the State and its political subdivisions for projects and purposes that promote the public welfare."

Section 23. "Whereas economic insecurity due to the interruption or loss of earning power, the lack of opportunity, or loss of ability to be productive, the denial of the right to live under favorable economic conditions in a wholesome environment are detrimental to the welfare of the people, it is hereby declared to be the policy of the State of Michigan that social insurance shall be provided for the people of the State in the proper exercise of the police power of the State. The elected officials of the State shall memoralize Congress in behalf of the people of the State for the establishment of a national insurance system."

"The Governor shall appoint a Social Insurance Commission consisting of one Commissioner . . . (and) a Social Insurance Council consisting of nine members, three members to be selected upon the recommendations of bona fide labor organizations of the State, three members to represent the employers of the State, and three members to represent the public. . . ."

"The following departments of the Social Insurance Commission are hereby created: The Department of Health Insurance, the Department of Employment Security, the Department of Disability Compensation, the Department of Workmen's Compensation, and the Department of Public Grants."

"The salary of the Commissioner shall be $10,000.00 per year,"

"Each employer . . . shall pay contributions (in addition to the contributions paid into the Unemployment Compensation Fund), equal to one and one-half per cent of remuneration for employment." *(No exemptions.* Editor.)

"Each person shall pay contributions on net income, as defined by the income tax statute of the United States, at the rate of one per cent on the first five thousand dollars, two per cent on more than five thousand dollars, but not exceeding twenty thousand dollars, and three per cent on more than twenty thousand dollars."

"Increases in the rate of contributions to the Social Insurance Fund may be provided by statute without any limitation."

"The Governor shall appoint a Health Insurance Council of twenty members, ten of whom shall be selected from a preferred list after polling the medical practitioners of the State who register for service with the Health Insurance Department, and ten of whom shall be selected to represent the public from persons who have expert knowledge of or who have had training in public health, health insurance or social insurance."

"All persons who have their normal place of residence in the State shall be qualified to receive health insurance benefits conferred by this section for themselves and any children for whom they have for the time being the care and control. . . . the benefits conferred by this section on qualified persons shall be such as to provide for the prevention of disease, and for the application of all necessary diagnostic and curative procedures and treatment, and for periodic physical examination. For the purposes of this section the health benefits shall be administered under the following heads, namely. (a) medical, surgical, and obstetrical benefits, (b) dental benefits, (c) pharmaceutical benefits, (d) hospital benefits, and (e) nursing benefits."

"The benefits referred to . . . shall include such special and technical procedures and services and the furnishing of appliances as may be deemed necessary to make effective the said benefits in the case of any qualified person. For the purpose of administering medical, surgical, and obstetrical benefit, the Director of Health Insurance shall, . . . make arrangements therefor with practitioners in medicine, surgery, and obstetrics who are qualified, duly licensed, and in good standing in the State, including specialists and consultants in medical, surgical, and obstetrical diagnosis, treatment, and procedures."

"The regulations and arrangements of aforesaid shall be such as to secure that qualified persons shall, subject to the provisions of this section, receive from medical practitioners with whom arrangements are so made all such adequate measures for the prevention of disease, and all such proper, necessary, and adequate medical, surgical, and obstetrical treatment, attendance, auxiliary service, laboratory service, and advice as may be prescribed. The regulations and arrangements aforesaid for laboratory services shall include chemical, bacteriological, pathological, diagnostic, and treatment x-ray, and related laboratory service, and physiotherapy, and special appliances prescribed by a practitioner, and eye glasses prescribed by a legally qualified practitioner. Arrangements with medical practitioners made under the provisions of this section may include arrangements with approved clinics or groups of practitioners practicing in coöperation."

"For the purpose of administering hospital benefits, the Director of Health Insurance shall, in accordance with regulations made hereunder, make arrangements for all necessary treatment of qualified persons in hospitals (including convalescent homes). The regulations and arrangements as aforesaid shall be made only with hospitals known as: (a) Non-profit, voluntary hospitals, (b) Municipal hospitals, (c) County hospitals, (d) State hospitals, (e) University hospitals."

"For the purpose of administering nursing benefit, the Director of Health Insurance shall, in accordance with regulations made hereunder, make arrangements for providing necessary nursing services for qualified persons, and for the effective and economic administration of such services."

"The State, through the State Accident Fund as provided for by statute, shall have the sole and exclusive right to insure workmen's compensation risks and shall collect premiums from all employers of the state for the payment of Workmen's Compensation as may be prescribed by statute."

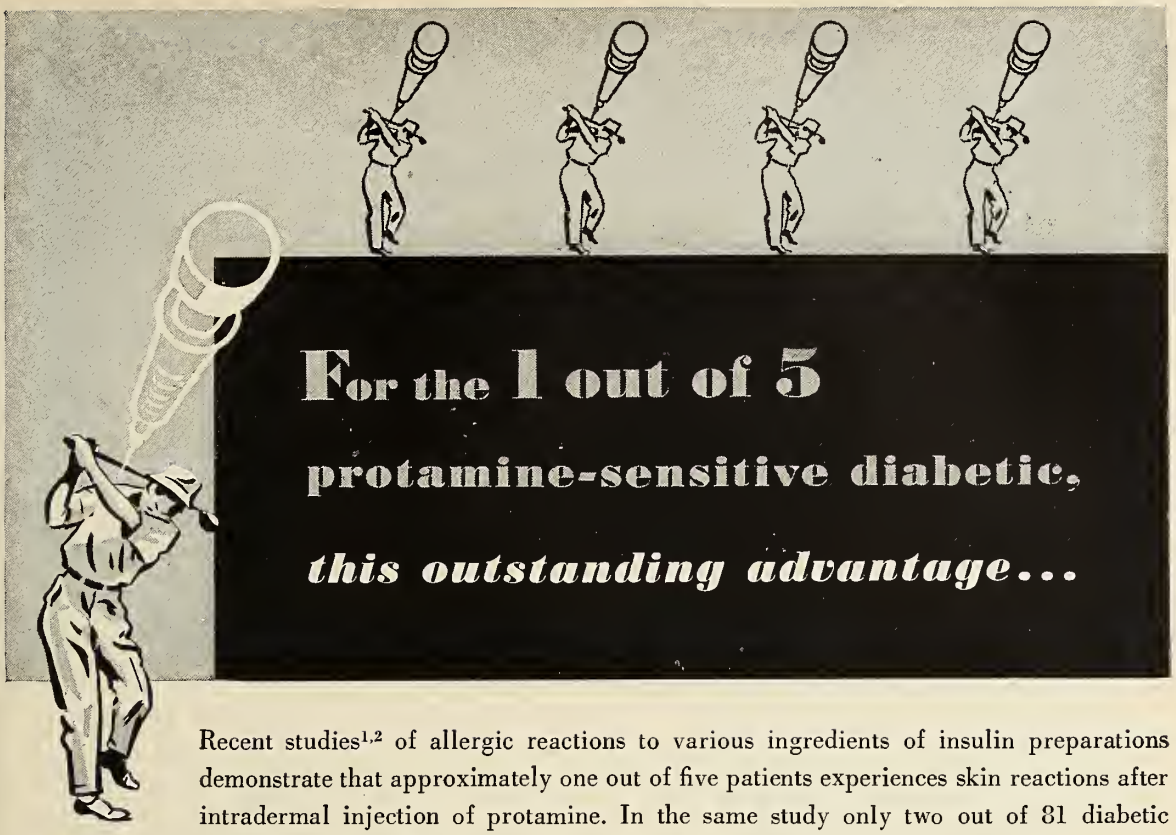
"The legislature shall have the power to pledge the credit of the State for the projects and purposes provided in this section."

(The petition in full covers ten closely typed pages.)

TRANSFER OF HEALTH FUNCTIONS OF DEPARTMENT OF LABOR TO U.S.P.H.S.

Representative Miller of Nebraska has introduced a bill, H.R. 4663, to transfer to the Federal Security Administrator and the Public Health Service, respec-

(Continued on Page 634)



Recent studies[1,2] of allergic reactions to various ingredients of insulin preparations demonstrate that approximately one out of five patients experiences skin reactions after intradermal injection of protamine. In the same study only two out of 81 diabetic patients exhibited sensitivity following the intradermal injection of globin.

Bauman,[1-3] and Duncan,[4] as well as others, have reported that patients who suffered from severe skin reactions following the use of protamine zinc insulin obtained immediate relief upon changing to globin insulin with zinc.

WITH 'WELLCOME' GLOBIN INSULIN WITH ZINC, these other advantages:

A single injection daily of 'Wellcome' Globin Insulin with Zinc will control many moderately severe and severe cases of diabetes, helping to reconcile patients who resent more frequent injections. Timed to achieve morning onset of action and then maximum effectiveness during the afternoon, 'Wellcome' Globin Insulin with Zinc provides control during peak eating and working hours. Diminishing action after 16 hours allays the dread of "night shock".

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'Wellcome' Globin Insulin with Zinc, a new advance in insulin therapy, is a clear solution permitting a more uniform dosage. It was developed in the Wellcome Research Laboratories, Tuckahoe, New York. U. S. Pat. No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc. 'Wellcome' Trademark Reg.

(1) Page, R. C., and Bauman, L.: J.A.M.A. **124**:704 (March 11) 1944. • (2) Bauman, L.: Bull. N. E. Med. Cen. V:17-21 (Feb.) 1943. • (3) Bauman, L.: Am. J. Med. Sc. **198**:475 (Oct.) 1939, ibid. **200**:299, 1940. • (4) Duncan, G. G., Diseases of Metabolism, Phila., Saunders Co., 1942, p. 782.

'WELLCOME' GLOBIN INSULIN WITH ZINC

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(Continued from Page 632)

tively, the functions of the Secretary of Labor and the Children's Bureau of the Department of Labor with respect to health. The bill is pending in the House Committee on Expenditures in the Executive Departments.

Section 1 of the bill provides that (a) all functions of the Secretary of Labor with respect to health, including the health phases of industrial hygiene, and including all functions of the Secretary of Labor under parts 1 and 2 of title 5 of the Social Security Act, as amended, are to be transferred to and vested in the Federal Security Administrator; and (b) that all functions of the Children's Bureau of the Department of Labor with respect to health are to be transferred to and vested in the Surgeon General of the Public Health Service.

COMMISSIONS FOR MALE NURSES

H.R. 4760, introduced by Representative Lane, Massachusetts, and pending in the House Committee on Military Affairs, proposes to grant temporary commissioned rank to certain male nurses serving in the armed forces.

This bill provides that any member of the land or naval forces of the United States who is or has been a registered male nurse and who is performing duties as a nurse comparable to the duties performed by members of the Army Nurse Corps (female) or the Navy Nurse Corps (female) shall be appointed by the Secretary of War or the Secretary of the Navy to the relative rank of second lieutenant in the Army or ensign in the Navy, as the case may be, and will receive the same pay and allowances and have the same authority as a female nurse of such relative rank.

SEEING-EYE DOGS FOR VETERANS

The President, on May 24, approved H.R. 4519, a bill authorizing an appropriation of $1,000,000 to enable the Administrator of Veterans' Affairs to provide seeing-eye or guide dogs trained for the aid of blind veterans who are entitled to disability compensation under laws administered by the Veterans' Administrator and to provide such veterans with mechanical electronic equipment for aiding them in overcoming the handicaps of blindness. All necessary travel expenses to and from their homes and incurred in becoming adjusted to seeing-eye or guide dogs will be paid from this appropriation.

THE BLIND AND DEAF

Brig.-Gen. Charles C. Hillman, writing in *The Journal of the American Medical Association,* squelches two rumors about soldier casualties.

One is that there is a lot of blindness resulting from wounds.

The other is that thousands of men will become deaf as a result of bomb blasts or the pounding given ear drums by airplane motors.

It isn't true.

In fact, the truth of the matter is almost unbelievably the opposite. As of January, 1944, there were ninety-nine veterans with varying degrees of blindness, and only seventeen* of these were totally blind. As to deafness, the general says that the Army anticipates no widespread problem.

These assurances should do much to relieve overanxiety felt by the kin and friends of servicemen. Rumor mongering can best be answered by the facts.

WAR MEDICINE

ARMY SURGEON GENERAL REPORTS FALLING DEATH RATE FROM DISEASE AND WOUNDS

Washington, D. C.—Today's American soldier is the healthiest ever to take the field against the nation's enemies, Major General Norman T. Kirk, Army Surgeon General, maintains.

The rigid screening process by which both civilian and military doctors have weeded out the physically and emotionally unfit is largely responsible, he said, in a recent nationwide broadcast of "The Doctor Fights."

In previous wars, the general reported, pneumonia has been responsible for many deaths but during the winter of 1943 something under 1 per cent of cases of pneumonia in the United States armed forces died of that disease."

"Meningitis, which fifty years ago, had a death rate approximating 80 per cent and which, twenty-five years ago, had been lowered to a death rate of 40 per cent, has today in our armed forces a death rate approximating 5 per cent," he continued. "In one great military installation there have been reported seventy-six consecutive cases of meningitis without a single death."

These figures, Gen. Kirk added, can be applied to most of the common diseases that affect mankind, particularly under military conditions.

"Never before has an army more physically fit than this one taken the field against our nation's enemies," he declared.

The low death rate, he continued, was a tribute not only to physicians but "particularly also the magnificent organization for medical research which is carried on during the war period."

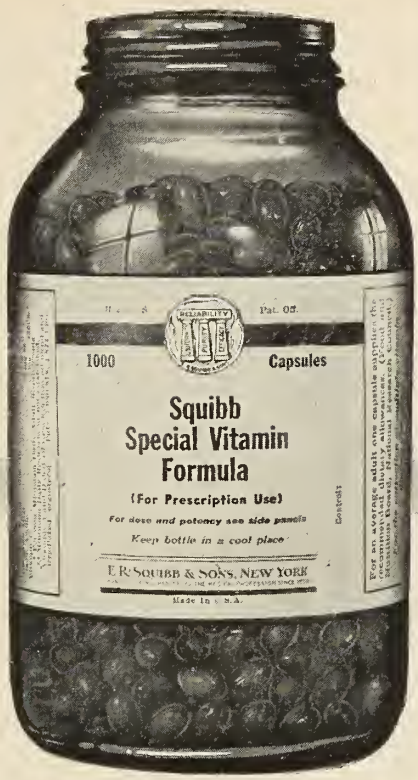
"This research," General Kirk said, "has been reflected in the exceedingly low death rates from wounds of all men not killed outright in the use of such remarkable products as blood plasma, the sulfonamide drugs, penicillin and in the preventive measures for the control of measles, meningitis, typhus and many tropical diseases."

CONTACT DERMATITIS FROM PENICILLIN

What is apparently the first case to be reported of contact dermatitis (inflammation of the skin) from penicillin is described in *The Journal of the American Medical Association* for July 29 by Major H. D. Pyle, MC, AUS, and Herbert Rattner, M.D., Chicago.

*A recent report gives seventy-three blind.

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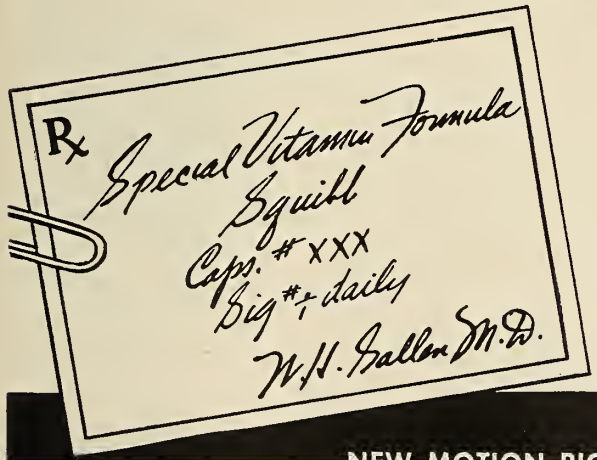
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Thiamine Hydrochloride	2 mg.
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Niacinamide	20 mg.
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HEAR

"WHAT THE PEOPLE OF MICHIGAN THINK OF MEDICINE"

GENERAL ASSEMBLY, THURSDAY, SEPTEMBER 28, 1944, 8:30 P.M.

BALLROOM, PANTLIND HOTEL, GRAND RAPIDS

A factual statement showing Medicine's virtues and faults, based on the survey made by the Michigan Health Council, will be presented by R. L. Novy, M.D., Detroit, President, Michigan Medical Service, and John F. Hunt, Chicago, Director of the survey.

»→ PREMIER RELEASE OF THE FACTS ←«

Members of the Michigan State Medical Society are urged to attend this meeting and hear the results, published for the first time, of this important Michigan poll.

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Barnes, Donald J.....Detroit
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Chostner, G. C.....Detroit
Clapper, Muir.....Detroit
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It is estimated that 22.7 per cent of the total national income, or $33.6 billion, was saved in 1943 by the people of the United States.

Table of Contents

War Casualties in a General Hospital in the U.S.A.
Col. R. H. Kennedy, MC, AUS 657

Malaria: A Current and Postwar Medical Problem.
L. T. Coggeshall, M.D. 662

Intussusception.
Louis J. Gariepy, M.D., and *Russell M. Atchison, M.D.* 665

Peculiarities in the Physiology of Newborn Patients.
Clement A. Smith, M.D. 668

Poliomyelitis: Contrast Between the Kenny and Orthodox Concepts with Results of Treatment.
Sister Elizabeth Kenny 673

President's Page:
Your September Vacation 679

Editorial:
Public Opinion 680
1944 Postgraduate Conference on War Medicine. 681

Past Presidents 682

The 79th Annual Session:
Outline of 1944 Postgraduate Conference on War Medicine 683
Invitation 684
Committee Reports 684
Technical Exhibits 690

You and Your Business 696

Michigan's Department of Health 698

Woman's Auxiliary 700

In Memoriam 704

County and Personal Activities 708

Correspondence 713

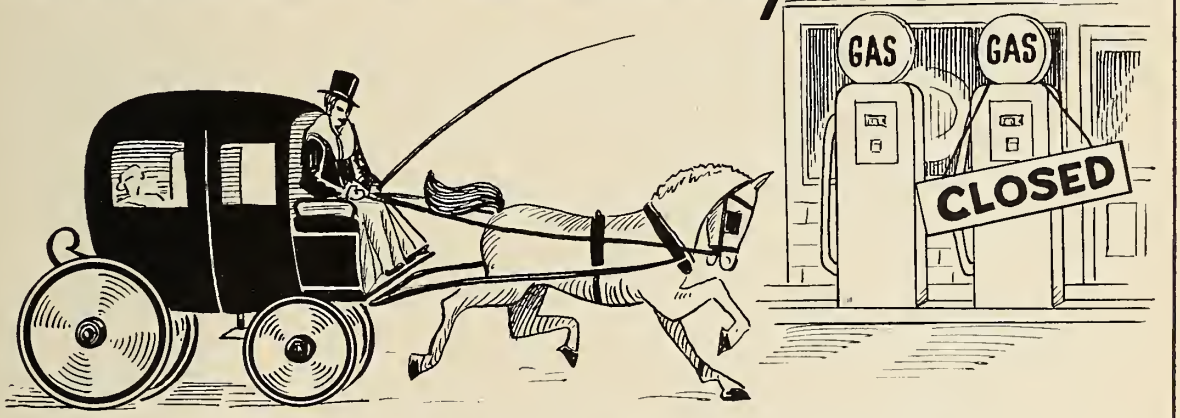
The Doctor's Library 717

Political Medicine 632

War Medicine 634

MSMS Roster—Supplemental List 636

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The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

Volume 43 August, 1944 Number 8

War Casualties in a General Hospital in the U.S.A.

By Col. R. H. Kennedy, M.C., A.U.S.
Battle Creek, Michigan



Colonel, MC, AUS, Chief of Surgical Service, Percy Jones General Hospital. In civilian life, Surgical Director, Beekman Hospital, and Attending Surgeon, New York Post-Graduate Hospital, New York City; Associate Clinical Professor of Surgery, Columbia University; Chairman, Committee on Fractures and Other Traumas, American College of Surgeons.

Patients are returning to this country in better condition than during the last war. They seem to have received definitive treatment earlier and of a more effective nature. Therefore it is practical to proceed with further treatment more promptly on arrival here. Skull defects are no longer allowed to remain. Artificial eyes are inserted early. The cooperation between plastic surgeons and dentists means much. Chest, abdominal and spinal injuries have been well treated and gas infection appears less of a problem. Plaster encasement has largely replaced traction. Vaseline gauze is regularly used for packing. The guillotine amputation is usual, but the necessity of immediate traction on the skin has not been sufficiently stressed. Prosthesis should be applied early. Nerve injuries and causalgia present a large problem. Malaria has become a usual companion on a surgical ward.

■ Some of you had experience in the last war at various points from the front line to posts in the zone of the interior. It may be of interest to all to note what difference there may be in the condition of the wounded man arriving at a General Hospital in this country in this war, as compared with twenty-five years ago. My experience the last time was entirely in casualty clearing station or base hospital in France or Belgium, but at least I know in what shape we were sending the men out for a trip across the ocean.

My present station accepts all types of patients but has been designated as an amputation center, a neurosurgical center, and a center for penicillin therapy. Of course proportions do not mean anything until the figures are all in as to losses and types of wounds from the front line to time of discharge. We do not know what proportion are able to reach an evacuation hospital for definitive treatment. From the condition of our patients, it would seem that the more seriously injured, who are still alive, may be held in hospitals abroad or at the ports of debarkation in this country. For, certainly, the condition of patients on arrival at our hospital has been remarkably good. Some have arrived within one month of injury with wounds healed. Osteomyelitis with later sequestration may be present, but sepsis is practically unknown and a temperature above normal on admission is a marked exception. The patients are not gaunt and worn, but appear well fed and are rarely anemic. Their morale is excellent.

Uniformly, they volunteer comments regarding the excellent medical care they have had from corpsmen, doctors and nurses, and frequently express their opinion that the medical corps is acquitting itself better than any other branch of the service. They seem really to have the sulfonamides for local and for oral use in their first aid kits, to have been instructed in their use and to have been filled with enough confidence so that they actually use these immediately. According to the men's stories, plasma is actually

Read at the Third Annual Conference on War Medicine, the Seventy-eighth Annual Session of the Michigan State Medical Society, Detroit, September 23, 1943.

at the front, is being used freely and the men feel is saving their lives.

Conditions of terrain vary so greatly in the different parts of the world where our troops are in action, that the time of arrival for first definitive treatment varies greatly. Suffice it to say that the litter bearer is still the most important cog in the wheel, whether he be a member of the band or a native working for three cigarettes. In some places it has been possible to fly the wounded out early and to have them on the operating table of an evacuation hospital two hours after they are wounded. At other points there may be as much as an eight-mile litter carry before any type of motor transportation is possible. Apparently early care will depend on the ingenuity of the individual battalion medical officer more than on any directives. According to the men the coöperation between army and navy medical units has been superb.

Among several hundred returning wounded men, our percentages of regions involved are shown in Table I.

TABLE I. PERCENTAGE OF REGIONS INVOLVED

Head	3.5%	Trunk	12 %
Face	4 %	Pelvis	2 %
Neck	2.5%	Genitalia	0.5%
Chest	8 %	Upper Extremity	23 %
Abdomen	1.5%	Lower Extremity	43 %
			100 %

Among the total number of wounds, there were 43.5 per cent showing fractures of the extremities, and 22 per cent nerve injuries.

There have been several skull injuries with cranial defects. The wounds have been either healed or clean with a scab. It has been possible to fill the defect by applying a tantalum plate, wounds have healed excellently and the patient has been out of bed in four or five days. The largest defect filled was about six by two and a half inches. The dental service has been of great assistance in making plaster molds of the unaffected side. By this means the shape of the affected side can be molded and the tantalum plate hammered to its proper shape before operation. The dentist has also proved valuable to tighten the fine tantalum wire used to fix the plate in shape through drill holes in the plate and skull. Little was attempted in the last war in replacing skull defects. Tantalum seems to have proved its value for this purpose.

With loss of an eye, replacement with an artificial one has often been done even before arrival at our hospital. If portions of lids, mucous membrane or bony structures are lost, plastic procedures are naturally required before an artificial eye can be fitted. One gains the impression that there must be eye surgeons in the evacuation and general hospitals overseas, whereas in the last war many of the enucleations were performed by general surgeons with little previous experience in this field.

Ears present a real problem of administration. Many claim deafness and discharge following a nearby bomb or shell explosion. These ears are usually dry, or practically so, on arrival and close questioning frequently brings out the fact that the soldier has known that he was growing deaf for some time, or that he has had recurrent attacks of discharging ears previously.

The maxillo-facial problems are being well handled with excellent coöperation from the dentists. This specialty largely came into being during and after the last war and we are fortunate in having trained plastic surgeons in the army, capable of working out each individual problem in this field. It seems that there are far fewer cases of this type than in the previous war, possibly due to lack of trench warfare, although the increase in bombs and land mines may be another explanation. The most serious maxillo-facial patient came in with the front of the mandible and floor of the mouth blown away and with a tracheotomy and gastrostomy in excellent condition. Since arrival it has been possible to apply a skin graft on a stent for a new floor of mouth, acrylic dental splints to preserve conditions preparatory to further grafting after the floor of the mouth heals and several operations to fashion new lips. The tracheotomy and gastrostomy tubes have been kept in place for several months, the former so that anesthesia may be administered whenever required with less risk, and the latter so that adequate nutrition will be maintained during the many necessary procedures in refashioning a mouth. Neither seems to disturb him. The Padgett dermatome has entirely changed the problem of skin grafting and the plastic surgeon is called on frequently by all sections to apply split thickness grafts. An extraordinary take was accomplished in a large sacral decubitus in a patient with cord injury and paraplegia. This was a sloughing wound on arrival, but under intensive care by a nurse it became covered with apparently

healthy granulations. Then a split thickness graft over three inches in diameter was applied. The immediate take was better than 90 per cent and the wound went on to complete healing.

One through and through wound of the upper neck was left only with slight restriction in protruding the tongue. He was returned to duty shortly after arrival. A similar wound lower down resulted in a perforation in each side of the esophagus. It had not been discovered until it reached us about five weeks after injury with wounds healed and showing no evidence of infection. However, discomfort from gurgling and the persistence of a mass in the right neck immediately above the clavicle induced us to explore the esophagus. The mediastinum seemed to be well walled off, but the opening in the esophagus could not be located, even though we found barium in the tissues. A drainage tube was placed down to the region of the esophagus, hoping that this would allow it to heal gradually by scar tissue. At first this seemed to be successful, but later the scar had to be opened again for a recurrence of drainage into the neck. We do not know yet whether this treatment will be successful.

Practically all the chest wounds have been either perforating from small missles or gutter wounds which had been debrided, and in two-thirds of the instances followed by empyema. We have seen none in which foreign bodies had been removed from the lungs. Most of the perforating wounds had had aspirations of blood one or several times before arrival and still required further aspiration after arrival. None became infected. The gutter wounds had been debrided and closed. Most required further attention for emypema or osteomyelitis of ribs. The more severe chest wounds either did not leave the front lines or must still be under treatment somewhere along the return trip. Some foreign bodies in the lung have been removed at our hospital and we believe this should be done generally when they are over 7 to 10 mm. in diameter to prevent serious trouble in the future.

We have received but 1.5 per cent wounds involving the abdominal cavity. Several had multiple perforations which were sutured. The two which involved small intestine only were healed on arrival and have done excellently. Two shell wounds of the rectum had been treated by permanent colostomy and came in in excellent condition. One Sicilian casualty was wounded on the first day and operated on shortly afterward during the return voyage from Sicily to North Africa.

Among the back injuries there have been a few cord injuries. All arrived with decubitus sores. There was one automatic bladder on arrival, one with suprapubic cystotomy, and the others with permanent catheters. Considerable bladder infection in all has been largely cleared since arrival for treatment in the same institution. All the bed sores are healing in well also. These patients will of course be transferred to Veterans' Administration Facilities as soon as they have reached maximum hospital improvement. One has had a cordotomy with considerable relief of his causalgia.

As in the last war, wounds of the extremities make up the bulk of the cases. Gas infection has not been much of a problem, unless wounds were closed. This should never be done in surgery near the front. Lack of gas may be due to the sulfa drugs, early operation and better debridement, but it is more probably the result of fighting over new country. I suspect that when we go into France, we shall see a rapid increase in the incidence of gas infection.

All the bone cases have arrived in plaster encasements, usually unpadded and uncut. A few have had pins incorporated in the plaster, usually one only. The pin holes have almost uniformly been infected. Many have had the plaster changed since leaving the general hospital abroad and before reaching us. None has arrived in traction splints. We have seen neither the Stader apparatus nor internal fixation. A drawing of the fracture and the date of the last change of plaster appears on many plaster encasements. These are of great assistance, since x-ray films and other records frequently do not accompany the patient and are sometimes permanently lost on the trip home. We have not seen plaster causing circulatory difficulty on arrival, although we have seen evidence that previous plasters had caused circulatory loss. Decubitus from plaster exists, but is not as common as one might expect, probably because most of those in plaster have not been transported for a few days. The quality of plaster is good, the encasements have been applied well, and broken plaster is the exception. I believe plaster encasement is the most comfortable means of immobilization for trans-

port by train or ship. It cannot be a happy situation to find oneself in, however, if the order is given to abandon ship. Splint traction fixation would hardly be an improvement in this dilemma and is not nearly as comfortable for a rough sea voyage.

Plaster is usually cut down shortly after arrival, wounds dressed, and radiographs made. Vaseline gauze is almost uniformly used for packing. So far we have seen nothing of bipp, dyes, et cetera. On dressing, it is the habit to clean the wound grossly, sprinkle the walls with sulfanilamide and repack all the crevices lightly with vaseline gauze. Fresh plaster is then applied for immobilization. The patient is kept in bed with the part elevated. No anesthesia usually is necessary for this redressing, although one is used if there is the slightest indication for it. Most wounds have been in reasonably good condition and the position of bone fragments fairly satisfactory. Wounds not doing well have been explored and in some instances soil, grass, and clothing have been found in addition to metallic foreign bodies shown in the x-ray. We do not explore for foreign bodies, unless we believe they are a source of continued discharge, in a location which will probably cause trouble in the future, or of very large size.

Most plastic procedures involving compound fractures and tendon injuries should be delayed a minimum of three months after complete healing of the wound. To institute treatment earlier will frequently mean failure. A booster dose of tetanus toxoid is a part of every pre-operative preparation.

Amputations have usually been of the guillotine type, as they always should be, preserving as much length as possible. However, there have been numerous instances in which traction has not been applied to the flaps immediately or at all. This is a part of the operative procedure and traction should be maintained until the wound is healed. The best form of traction is accomplished by brushing ace adherent over the complete circumference of the extremity up to the next proximal joint and drawing stockinette over this. The stockinette should adhere as far down as the edge of the wound. This can be tied over the dressings and a rope incorporated in the knot to which weights over a pulley are fastened. Four to seven pounds is usually sufficient. Unless traction is maintained, more bone, often two or three inches, will have to be sacrificed at re-amputation. Following the use of traction oftentimes the bone will be entirely covered by soft parts when healing takes place. If the stump is not too long, the only plastic repair required then will be an excision of the scar of skin and soft parts, beveling away excess muscle, closing fascia over the end of the bone and fashioning skin and soft parts so that there will be no redundant tissue. More commonly the scar is adherent to bone and it is necessary to remove a thin sliver of bone surface with the rest of the scar.

In the last war, chop amputation or immediate closure of flaps was much more frequent than a guillotine amputation. Infection and sloughing were prolonged, progressive osteomyelitis was not uncommon and Carrel-Dakin dressings had to be continued for a long period. When infection had subsided marked edema and deep retraction by scar was present. Under present treatment these conditions exist rarely. We have seen but few cases where the presence of slough or the size of the open wound made the use of Dakinization advisable. The policy of amputating at the lowest possible level at the first procedure has been much more closely adhered to, allowing of more opportunities to do a re-amputation at the ideal level. Without prolonged infection the bulbous edematous stump has been much less frequent.

Instructions from The Surgeon General's Office require that—"All major amputees will be transferred as early as practicable after the primary amputation to general hospitals designated as amputation centers for revision of stumps or fitting of prosthesis. All cases, except disarticulations of the hip, the shoulder, or those with equivalent stumps, will be fitted with a proper temporary prosthesis before discharge from the army.

"Before discharge, an upper extremity amputee will be fitted with an acceptable prosthesis and taught its use as well as to write, dress, and otherwise care for himself with his remaining hand.

"Lower extremity amputees will be properly fitted with a standard temporary prosthesis, taught its use, and will be able to walk on level ground without the aid of crutch or cane; also, and before discharge, a refit will be effected after the original shrinkage has occurred. Each amputee will be issued three light wool stump

socks (later obtainable through Veterans' Facilities). Six months later the patient will report to Veteran's Facilities for fitting of permanent type prosthesis."

We believe this method will insure many fewer corner pencil salesmen after this war. It is amazing how well these men walk on a temporary prosthesis after only three or four days' trial.

Penetrating and perforating wounds of the feet present a grave problem for army service. The metatarsal or tarsal bones are usually involved. Bones and soft parts may heal well, but arthritis will usually be present and movement of toes and the midfoot is restricted and painful. Skin scars may cause discomfort in wearing a heavy army shoe. The wounds may be small and the original bony injury not marked, but many of these men will never be able to hike many miles a day. A man with poorly functioning feet is one of the greatest liabilities to the army. Land mines are an infernal contraption, for which the men have the greatest respect. One misguided step and a foot will be blown off, even if nothing worse happens. The men frequently give a history of having been hit with shrapnel. We have seen no evidence that shrapnel balls—so common the last time, smooth, and the size of marbles—are in use in this war. The men are referring to either bomb or shell fragments.

Peripheral nerve injuries are frequent. It is often difficult to learn whether nerves have been sutured in the forward areas or not. Therefore an exploration is frequently the conservative procedure rather than waiting for several months to learn whether there will be return of function or sensation. In some instances, separated nerve, in others, partial tearing, neuroma formation, or surrounding or infiltrating scar have been found. Dissection, suture, excision of scar, and neurolysis have all proved valuable. Rapid apparent immediate results have been observed in some of the cases of the latter two types. It seems that peripheral nerve injuries are much more frequent than in the last war, but it may be that less attention was paid to them. Support to antagonize stretching of paralyzed muscles is of prime importance from the first.

Causalgia is common and treatment should be commenced as early as possible, before the patient becomes a drug addict and before pain becomes fixed in the cerebral cortex. Paravertebral block, sympathectomy, cordotomy, all have a place in this most distressing condition.

The general mechanization of war has added many other combat injuries besides wounds, e.g., ruptured nucleus pulposus while riding in jeeps, simple and compound fractures of all types from overturning motor vehicles and plane accidents, broken ankles from parachute jumps, et cetera. Climatic conditions bring us amputations for frozen feet. These men, the same as those wounded by gunfire, must often be evacuated for the long journey back to this country and a general hospital. Burns, thus far, have been seen rarely as a result of overseas combat.

One other condition merits real attention. These men are coming back with malaria. Some have gone for months without a chill, others have had suppressive treatment until they left for this country and never had a chill until after arrival. It almost seems that any physical or psychic trauma will mobilize the plasmodium. At any rate it is extremely upsetting to operate on a man who is quite well and have him shoot a temperature of 105 degrees that evening with a chill. Only the finding of the plasmodium relieves our minds. We suspect that this may be a common finding in civilian operations on these patients from now on.

War casualties require the services in a general hospital of every type of specialist in the surgery of trauma. Team work is returning these men to the best possible condition in the shortest time.

MSMS

GEORGE DOCK, M.D., D.S.A.

The Distinguished Service Award of the American Medical Association was brought into being in order to honor each year a physician of the United States, whose work through the years in scientific medicine or public health had been so notable that special recognition and appreciation from his fellow physicians should be tendered, and whose work was not in organizational matters which might lead to election as president, the really highest honor we can render. This year the Distinguished Service Award goes to George Dock, for many years Professor of Medicine at the University of Michigan. He now lives in California and has devoted much time to developing the library of the Los Angeles County Medical Society.

Malaria: A Current and Post-war Medical Problem

By L. T. Coggeshall, M.D.
Ann Arbor, Michigan

School of Public Health, University of Michigan

■ Malaria was once the great scourge of the Northwest Territories and when our government was debating the feasibility of opening up that portion which was later to be known as Michigan, a presidential commission reported in 1790 that it was ill advised and prophesied the territory would probably remain uninhabitable because of the "remittent fevers." Although this prediction did not hold true, the earliest settlers were plagued with "chills and fever," "ague," or malaria, as were their followers and offspring until long after the Civil War. Even though it killed relatively few people, because it was predominantly of the mild tertian type, almost everyone was incapacitated for several weeks each autumn. Quinine was a household necessity and whiskey with wormwood highly recommended. Since those times, but mostly in the last half century, malaria has all but disappeared from this general area, and is confined largely to the southeastern states.

What caused this has never been entirely explained, although in all probability it came about as the result of a combination of unplanned circumstances. The clearing of forests, the draining of the soil, installation of water and sewage systems and the construction of better homes have undoubtedly served to decrease both the numbers of infected individuals and the vector of malaria, the anopheline mosquito. Until recently, malaria has almost become a forgotten word to the layman, and the physician thought of it as a disease confined to the tropics. In a few places along the river bottoms in the southern and western parts of the state, it has smoldered along and there has been an occasional imported case, but it is the fortunate medical class that has had the opportunity to see a naturally acquired case of malaria. However, from this brief historical account it is quite evident that under optimal conditions malaria once flourished in this area.

Let us quickly turn to the malarial problem in other parts of the world. Even before the present war there was no disagreement with the statement that "universally there were more cases of malaria than any other infectious disease." In India, for example, it is estimated that 100,000,000 cases and 3,000,000 deaths occur annually. India is no exception but is cited only because the greatest effort has been made there to obtain accurate vital statistics. In Ceylon in 1935 an epidemic occurred in a population of 5,000,000 people and there were one and a half million cases accompanied by 70,000 deaths. In many of the countries, especially those nearer the equator, it is not unusual to find the malarial rate approaches 100 per cent of the population. In the United States it is probable there are a million cases annually, with approximately 500 deaths. For the past 20 years it has been noted in this country that the incidence of malaria fluctuates with peaks about every fifth year irrespective of control measures. We are now at the bottom of such a cycle and even under normal conditions we could expect to see a substantial increase. Suffice to state that in times of peace malaria is one of the world's outstanding medical problems, but when associated with war its fury seems to have no limits. In this war its devastating effect is already well known to the military medical services and it is a rare correspondent who does not frequently refer to this malady. At the present time we must be concerned with the prevention of malaria on the various battle fronts, the care of the infected and finally anticipate the danger this disease holds for us in the future.

Although it is easy to assume an alarmist attitude about the danger malaria holds for us especially in the postwar period, a certain degree of overemphasis may be justifiable in order to be sure that we do not become remiss in our responsibilities.

Let us evaluate the factors which may permit us to anticipate the seriousness of the problem. The first important factor in the epidemiological picture is the alarming rate at which our troops are acquiring malaria. Incidentally, the Jap is just as susceptible, as the female mosquito has no racial or political preferences in seeking her blood meal. A map showing the most malarious areas of the world can almost be superimposed

Read before the Third Annual Postgraduate Conference on War Medicine, the Seventy-eight Annual Session of the Michigan State Medical Society, September 24, 1943, Detroit.

upon the present and probable fronts of this war. At the fall of Bataan the press reported that most of our men were suffering from clinical malaria. In Guadalcanal, parts of New Guinea, Buna and many other places in the Pacific over 50 per cent of the troops have already contracted the disease. A correspondent reported recently that Sicily was the third worst place in the world as far as malaria was concerned. The British and French were immobilized in parts of the Balkans during the last war. South China, Burma and India and the Island of Formosa can match high rates with the worst. None can really be worse than others when the number of native cases in most of the countries we are now fighting almost coincides with the total population. When our susceptible troops are brought into contact with these huge reservoirs of infection plus an abundance of efficient mosquito vectors, the only possible result is an excessive malarial rate. As Surg. General Kirk of the U. S. Army recently stated, every war seems to be associated with an outstanding medical problem, typhoid in the Civil and Spanish-American Wars, influenza in 1918, and malaria thus far has kept this war from becoming a medical triumph.

Why can't a more successful battle be waged against this infection? Certainly it is not the lack of effort or understanding of methods. As Sir Leonard Rogers stated, "The simplicity of the theory of malaria control is only surpassed by the difficulties of application."

The tools so favorable to combat many diseases are not available for malaria. For example, there is no effective vaccine that will immunize one when going into an endemic malarial area and the hope for such a weapon is far from promising. A severe clinical attack produces only a transitory immunity against the same type of malaria and none against the other two. Actually one strain will not protect against the numerous others within the same species.

A question frequently asked about malaria concerns the immunology of the disease. Why do our soldiers suffer so much while the native is so resistant? It is because the native acquired his tolerance to malaria the first few months of life. During that period, malaria claims most of its victims as practically all become infected and many die. If they survive they are constantly exposed to infected mosquitoes and gradually acquire a tolerance to the infection, or a balance where neither man nor malaria is quite able to destroy the other, so they learn to exist together. The susceptible soldier has the same resistance as the native baby and no more or less.

We have two antimalarial drugs, namely, quinine and atabrine. There is a third drug called plasmochin, at one time highly recommended because of its deleterious effect on the sexual forms of the parasite. There are reports that its usage will result in fewer relapses but this is a very doubtful claim and also since it is very toxic the Army and Navy Medical Services no longer recommend its usage. The inaccessibility to the source of quinine has resulted in its limited use which would have almost certainly resulted in a disaster far greater than any we have ever experienced if it had not been for atabrine, a synthetic drug which is just as effective. Both drugs have a dramatic effect on the acute infection and are responsible for saving of thousands of lives annually, especially those with falciparum malaria. Neither can be praised too highly yet it is well to recognize their limitations, the chief one being their inability to prevent the inception of the infection, as they only suppress the clinical manifestations. Even here there are failures and men will develop symptoms in spite of the drug. There has been recent controversy on this point as some hold the opinion that those who for willful or careless reasons do not take the drug are the ones who come down. Careful and detailed histories have shown this assumption to be untrue, although those who do not take the drug will be the first to become ill. Many instances are recorded where clinical malaria has developed while the men in Guadalcanal were taking three times the recommended suppressive dosage or 0.3 gms. daily. In other areas no clinical symptoms will occur on a suppressive dosage of 0.4 gms. per week. The probable explanation is that the effectiveness of the drug depends upon the number of bites a soldier receives from infected mosquitoes. The greater the infecting dosage the higher must be the blood level of the suppressive drug. Whatever the answer, it is quite obvious that drugs now available have no prophylactic value nor can they be relied upon to suppress the clinical manifestations in all instances.

Another important factor in this problem concerns the biological nature of the disease itself. Malaria is an acute disease but characterized by a marked tendency for chronicity and frequent

relapses. With the more familiar strains, about 30 per cent of vivax or simple tertian malarial infections will relapse, falciparum or the malignant tertian variety in about 10 per cent of the instances, while quartan malaria may persist almost indefinitely. The various strains within each of these types can relapse at different rates, and cannot be lowered *appreciably if at all,* even with increased or prolonged medication, bed rest and careful feeding. For example, the strain of vivax malaria acquired by our soldiers at Guadalcanal and New Guinea possesses a high relapse rate, probably in excess of 40 per cent, and many of the men have had repeated relapses after returning to this country while under the most ideal physical surroundings and expert medical care. Therefore, the chief biological feature of malaria, like many of the other tropical parasitic diseases, is its long duration.

Since neither a vaccine nor an ideal drug is available, most of the fight against malaria must be made against the mosquito, a difficult task under stable surroundings, but really a formidable one under combat conditions. In the Southwest Pacific, malarial survey and control teams are advancing with the troops. While under fire or during rapid advances, only repellents, insecticides, bed nets and atabrine can be used. These measures can be supplemented by more effective ones as drainage, oiling and Paris green dusting after active fighting is over. The malarial rates have already begun to decline in some of the worst places after initiating control measures.

With the excessive malarial rates overseas, what are the potential dangers that malaria has in store for us? In the first place, a very substantial proportion of all cases of malaria acquired overseas will be brought back because, as stated previously, malaria is a chronic disease. In numbers this does not mean an occasional case but probably thousands. Perhaps the best way to visualize the problem is to trace the progress of a group of men who have seen active service in an area where malaria is heavily endemic and who are being invalided home for various medical reasons. In some areas it was found that of those who served for more than a month overseas, the majority had malaria. Their attacks were about equally divided between vivax and falciparum malaria. Practically all of them took suppressive atabrine because little difficulty is encountered in inducing men to take this protective drug where malaria is severe. As soon as they were evacuated from the malarial area or not more than three weeks later, suppressive medication was usually discontinued. On admission to the various general hospitals, a blood smear examination reveals that only two or three per cent were positive. Yet as they continued to remain in the hospital, more and more of them have clinical recurrences after six months we find that of those men who had vivax malaria overseas, more than 50 per cent have relapsed in the hospitals here and 5 per cent or more of the falciparum infections have reappeared. Many of the vivax cases have had an acute clinical attack every month or six weeks and some have had as many as ten severe relapses. Thus far we have only spoken of the group with a definite past history of malaria in the field. What about the exposed group who did not have recognizable malaria overseas and were returned because of wounds or other disorders? Of those returning from the Southwest Pacific with that story, 20 per cent have relapsed, many as long as six months after their first exposure. Undoubtedly their initial infection was kept smothered by atabrine so that no clinical symptoms, at least severe ones, appeared. Many of these men have already been returned to civilian life because they are incapacitated for further military duty. Others will be released to military duty where they will be treated when they relapse, and unless reinfected most infections will probably eliminate themselves by the end of a year or perhaps two.

With all these relapsing infections, both in the Service Hospitals and in civilian life, what are the chances for local outbreaks or epidemics? The mosquito *Anopheles quadrimaculatus,* responsible for the transmission of malaria in the United States, is abundantly present as far north or farther than the southern Canadian border. Allowing three generations per season since malaria disappeared from this area approximately 50 years ago, our local malaria mosquito has passed through approximately 150 generations after the last intimate contact with the disease. The introduced strains of malaria from Italy, Southwest Pacific or other places might be less adapted to our mosquitoes than the native malaria and all the scattered cases would eventually die for the lack of an insect to carry the disease because that is the only mode of transmission. To prove this point, Dr. R. L. Laird, School of

Public Health, University of Michigan, has collected and hatched out *Anopheles quadrimaculatus* larvæ from the Huron River near Ann Arbor and with the coöperation of Colonel Martin at the Percy Jones General Hospital, these mosquitoes were allowed to obtain blood meals from volunteer patients suffering from malaria contracted in the different parts of the Southwest Pacific. It was found that the local mosquito became heavily infected. Thus all requirements for transmission are satisfied, namely, large susceptible population, an abundance of efficient vectors and the number of relapsing cases are gradually accumulating. The danger for the South is probably greater than for the North because conditions for transmission are more favorable. There is no comfort in the fact that malaria is indigenous to that area because, as stated above, the tolerance an individual or a community develops against one strain offers a minimum of protection against introduced ones, and those now being acquired elsewhere are to be feared because of their high relapse rate.

The local physician must now think of malaria when any unexplained fever develops either in the returning serviceman or civilian. A tragic example might better illustrate the point. The flight engineer on a transoceanic plane which carried an important person across the ocean returned to this country. While on a brief vacation he became ill and was considered to have "summer influenza." Six hours before death a blood smear revealed an overwhelming malarial infection. If made a few days earlier, a valuable life could have been saved by treatment. Untreated falciparum malaria will kill. A stained blood smear with the parasite is the only certain diagnostic point and a negative smear has little or no meaning other than the parasite could not be found.

Every discharged soldier, whether only exposed or with a past malarial history, should carry with him this information for the local health officer or physician, who can then be better prepared to recognize the relapses or outbreaks and institute measures for control.

In summary, malaria is the tropical disease most to be feared of all those with which our men are now in contact. They are becoming infected in many parts of the world and are returning in large numbers with their latent infections. It has been found already that some of the acquired strains are particularly bad because of the high relapse rate. We have a highly susceptible population, and no place in the United States except those few areas 3,000 feet or higher is safe, because of widespread distribution of the malarial mosquito. At present malaria is certainly a potential problem and only time will tell whether the introduced strains will succeed in establishing themselves but it will be the astute physician or health officer who keeps malaria constantly in mind and makes every effort to recognize and promptly treat the acute infections, destroy the adjacent breeding places of the mosquito or quarantine man from her bite.

MSMS

Intussusception

By Louis J. Gariepy, M.D.
and
Russell M. Atchison, M.D.



L. J. Gariepy

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This paper covers an experience of a period of five years, namely, from January 16, 1939, to January 16, 1944, in the management of Intussusception. We have endeavored to present a statistical study emphasizing the frequency of its occurrence and also the fact that the possibility of Intussusception should be kept in mind when dealing with patients with severe abdominal pain. The treatment, namely, immediate operation, can be successful only where early diagnosis following the proper assessment of such symptoms as (a) initial shock (b) colicky pain (c) initial vomiting (d) bloody stools (e) palpable mass, is made.

■ "Intussusception," derived from the Latin words "intus," within, and "suscipere," to receive, specifically an invagination or indigitation

of a portion of the intestine into an adjacent portion is a pathological entity which demands the utmost in clinical acuity and observation from the physician to avoid grevious errors and subsequent embarrassment.

Intussusception may be divided into two main groups, viz., large and small intestinal invagination; each again divided into two sub groups. The iliocecal, and the pure colic constitute the intussusception of the large bowel. The iliocolic and the enteric are the small intestine invaginations.

Age Group. The majority of instances of the disease occurs in infants under one year of age. Wangensteen found that more than one-half of the cases occurred during this period of life, and that of these most were between the fourth and ninth months.

The Cause of Intussusception. There have been many explanations of the cause of intussusception among which the abuse of cathartics has held a high place. But in the cases studied in this series, there has been no history that substantiates this belief. Intussusception occurring commonly in the age group between the third and ninth months likely is caused by dietary changes and antiperistalsis, resulting from the attempts of the bowel to adjust itself to a new regime. Weaning from the breast has been suggested sometimes as a cause but experience does not bear this out. It is probably because of a poor adjustment of the intestinal gradient to changing dietary environment.

Adult cases of intussusception usually have an associated Meckel's diverticulum or an intrinsic lesion of the bowel. Intussusception in the older age group is consequently less frequent.

Symptoms of Intussusception. Much has been written about the symptoms of intussusception, viz., intermittent pain, bloody stools and initial vomiting associated with a palpable tumor mass in the abdomen, but very little has been mentioned about initial shock that attends every case of intussusception. This picture of shock is present in varying degrees and, if looked for carefully, can always be found. It is a very helpful diagnostic sign and should not be disregarded. Wangensteen mentions shock in reference to blood loss resulting from strangulating obstruction in which the blood loss into the infarcted segment is an item of real importance, but no reference is made to initial shock. The initial shock bears an indirect relationship to the age and a direct relationship to the extent of the intussusception point. One case vividly illustrates this:

A four-months-old male infant after being given a milk formula was being placed in his crib and suddenly cried out and turned pale. The child was brought to the office immediately in a morbid condition. The respiratory rate had decreased to about two per minute. The radial pulse was not palpable and the heart sounds were barely audible at the cardiac apex. Artificial respiration by the resuscitator, coramine and caffeine sodium benzoate intramuscularly were necessary to keep the infant alive. About one and one-half hours of continuous oxygen the child was able of its own volition to maintain a normal respiratory rate and could be examined. A mass was felt in the right upper quadrant of the abdomen and a bloody mucoid discharge was returned by a low enema. The infant's condition being improved, he was operated upon three hours after the onset of the invagination. On opening the peritoneum a small amount of fluid was present. The intussusception was found to involve the ascending and a portion of the transverse colon. It was gently reduced and the patient made an uneventful recovery. In this case the picture of shock overshadowed the disease to such an extent that it was not safe even to examine the infant in the first one and one-half hours after its commencement.

To recapitulate, much has been written concerning late shock in this condition, but the initial shock is very important in recognition and differential diagnosis of intussusception.

Growth and Extension of Intussusception.— Souttar describes the extension of an intussusception as follows: "Its growth occurs exclusively at the neck. The apex of the intussusception soon becomes edematous, stiff and swollen, and once this happens it is impossible for the apex to change. The driving force is supplied entirely by the ensheathing layer as intussuscipiens. As in normal peristalsis the circular fibers of the sheath contract strongly above, drawing the intussusception on and forming a fixed point from which the longitudinal fibers can act. These act in one of two ways: If the sheath is loose, they pull it over the intussusception like a sleeve. If it is tight, they drive the intussusception into it."

Therefore, it is apparent that the earlier the invagination is diagnosed the less the involvement and the lower the mortality rate.

The surgeon, many times in those cases operated upon early in the disease, is impressed by the extent of the intussusception, which could be explained if one could advance the following conclusion: the degree of an early intussusception varies directly to the initial antiperistaltic force causing the initial intestinal invagination, thus if a strong antiperistaltic action caused four inches of the intestine to become the intussusception, faster progress of the process could be expected if the intussusception was but one inch. Granted that this conclusion is true, it could also be said that the greater the initial antiperistaltic wave, the greater the invagination, the greater the initial shock and the greater the progress.

Statistical Report.—Up to this time, out of a total of 62,158 cases, fourteen patients were admitted to Mount Carmel Mercy Hospital with a diagnosis of intussusception. Two of the patients had a spontaneous reduction of the intussusception by the time preliminary laboratory studies had been completed and before examination by the resident physician. Thus we will concern ourselves with twelve proven cases.

One case, that of a one-month-old male infant, which had been followed carefully for twenty-four hours previous to admission, had the intussusception reduced by a high colonic enema. Five of the twelve cases had initial vomiting, or 41.6 per cent. Twelve of the twelve cases had recurring pain, or 100 per cent. Eight of the twelve demonstrated bloody stools, or 66.7 per cent. Nine out of twelve had a palpable abdominal mass, or 75 per cent. Nine patients of the eleven operated upon had the intussusception corrected, and survived, giving a mortality rate of 18.2 per cent. Of these eleven, the operative procedure was simple reduction without resection in nine instances, with an associated appendectomy being performed four times or in 36.3 per cent of the cases. One patient was found to have such an extensive involvement that it was impossible to reduce the intussusception, the invagination being of the iliocolic type and extending to the rectum. No resection was done and the infant died one hour after returning from surgery. This eleven-month-old female infant had had a seventy-two-hour typical history of initial vomiting, periodic attacks of pain, bloody stools, and a palpable abdominal mass in the right upper quadrant. Bowel resection was attempted in one case, with the child dying several hours after the operation. This infant had a fourteen-hour history of the disease previous to attempted surgical relief.

All patients operated upon, that survived, had a postoperative temperature elevation to a mean of 102 degrees for approximately forty-eight hours following surgery. The leukocytic count was correspondingly elevated.

Of the twelve patients with demonstrable pathology, nine were between two and eleven months of age and constituted 75 per cent of the total number of cases. The youngest was one month of age, the oldest seven years. Nine were males and three were females, or 75 per cent were males and 25 per cent were females.

Summary

In conclusion the treatment of intussusception depends upon:

(1) Early diagnosis
  (a) Intermittent pain
  (b) Initial shock
  (c) Initial vomiting
  (d) Bloody stool
  (e) Palpable abdominal tumor varying in consistency.
(2) Immediate operation.

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LEUKEMIA INCIDENCE AMONG DOCTORS

Leukemia may occur in workers with radiation from x-ray or radium under conditions like those in which cancer of the skin due to radiation can arise, *The Journal of the American Medical Association* for April 15 points out. Exposure to x-rays under experimental conditions favors the development of leukemia in animals. Since high energy radiations may play a part in human leukemia, workers in the National Cancer Institute have compared the incidence of leukemia in physicians and in the general population on the basis of the death lists of physicians in *The Journal*, the mortality reports of the United States Bureau of the Census and an unpublished compilation of the United States Public Health Service. The ratio of deaths from leukemia to deaths from cancer, the ratio of deaths from leukemia to total death rates, and death rates from leukemia were studied with the result that leukemia "was recognized approximately 1.7 times more frequently among physicians than among white males in the general population." The result is in accord with the increase in the incidence of leukemia in animals exposed to x-rays. Whatever the full meaning of the data at hand may be, the hazards of radiation require the strict maintenance of complete protection at all times.

Peculiarities in the Physiology of Newborn Patients

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Since the first two weeks after birth constitute the period during which a large number of pediatric fatalities occur, certain physiologic attributes of that period are here reviewed. It is pointed out that movements of the respiratory muscles may not occur during late fetal life, that, although the lungs may require days for full expansion, minutes usually suffice for raising blood oxygen conditions to adult levels after birth, and that the newborn subject survives anoxia which would kill an adult—though not always with complete freedom from harm. Circulatory, renal, gastro-intestinal, and other peculiarities of the newborn are also described and applied to clinical situations.

■ The largest number of those fatalities which we as pediatricians are banded together to combat occur in infancy, so that, unlike our brothers in internal medicine, we feel less uneasy about our patients the older they grow. It was not long ago that the major contribution to infant (and pediatric) mortality came from pneumonia and from diarrheal diseases occurring after the first few months of life had passed. I recall that in the earlier days of both the automobile and the practice of pediatrics, the Indiana philosopher Abe Martin, whose wisdom appeared daily in the newspapers, said "Touring cars are like babies. Everything happens to 'em in the second summer." With progress in pediatrics and sanitation, the threat to infants has been shifted away from that period, so that now if an infant survives his first month, his first or even second summer holds relatively few terrors. Thus, as experience shows, we now face the problem of whittling down infant mortality by an attack during the first month, and especially the earliest days of life.[3] To do this demands that we marshal our knowledge as to the ways in which these smallest and youngest patients differ from larger and older ones. That is the pretext with which I have chosen the present subject of discussion.

It is impossible in the limits of your time and my information to cover the entire field in any detail. Therefore, I propose to review certain aspects and to leave many others completely untouched. Among all of the divisions of physiology which we may explore this noon, it is interesting to note that the newborn patient has three main aspects in which he differs from his older brothers and sisters. The *first* and perhaps most obvious is that he is going through an adjustment period. Most of his physiological processes either are completely novel acts for him (like the digestion of food), or, like the circulation of blood, are acts which he performed before but in quite a different fashion. The *second* peculiarity about newborn infants is the mere delicacy and fragility of the structures and organs which they live—and this sometimes has been underemphasized and sometimes overemphasized in our approach to them. A *third*, and very interesting fact about little babies, is that in certain ways they pay that metabolic penalty for size which is exacted of all small creatures. We are not so much the slaves of our body mass as of our body surface; as any solid body is made smaller, its surface increases in proportion to its weight—and this is why in any given period of time a mouse uses up ten times as much oxygen per unit of its weight as does a man. Here and there we see physiological pecularities of small infants which stem directly from this increase of metabolism demanded by disproportionate surface area.

As an approach to *respiratory physiology*, it is usually considered that the concept of respiratory movement *in utero* is a very modern one. Actually, it was known to writers a hundred years and more ago that if animal fetuses are inspected *in utero* they will be observed to make rhythmical thoracic movements. The modern tendency, however, has been to assume that respiration after birth is merely the resumption of a foregoing constant physiological process. It is interesting to note what Ahlfeld,[1] who made persistent and careful studies of animal and human fetal respiration, said about tambour trac-

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ings of this fetal activity obtained from the abdomens of pregnant women. "Sometimes," he stated, "fetal respiratory movements *in utero* continue for an hour." This is certainly not a *constant* physiological activity.

If, on the other hand, the fetus does make occasional or intermittent respiratory movements *in utero,* it would be extremely helpful to correlate the mechanism behind these with the mechanism responsible for the onset of breathing at birth. And this is no academic question for until we know why a baby does begin to breathe when it emerges from the uterus we shall scarcely be sure why some babies do not. The studies of Snyder and his colleagues[16] on the one hand and of Windle and his group[20] on the other can still not be reconciled. The former say that experimental animals and human fetuses and infants start respiratory activity *in utero* and continue it unless lack of oxygen disturbs the mechanism involved. The latter say that fetuses only "breathe" *in utero* and babies only breathe at birth because some slight lack of oxygen has *stimulated* them to do so. For my own part, I still am inclined to think of three zones of prenatal and post-natal existence. In the first of these the supply of oxygen (and removal of CO_2) the mother's body is just sufficient so that fetal respiratory activity is not stimulated. In the second, some transient interference (or the permanent interference of birth) cuts down the oxygen supply or disturbs CO_2 removal so that respiration is stimulated. In the third and lowest zone more gross or prolonged disturbances in oxygen supply bring about a total or partial unresponsiveness and the experimental fetus ceases its respiratory movement, or the newborn infant presents the picture of asphyxia.

Although this all remains in the field of opinion, we do have one interesting fact about the sensitivity of newborn creatures to oxygen lack. This is that mammals of all species are (fortunately) born with a relatively enormous ability to withstand anoxia.[5] Newborn puppies, for example, will remain alive three times as long without oxygen as will full grown dogs. I shall cite as an illustration a human infant in whom respiration did not begin until fourteen minutes after birth, which, physiologists tell me, is twice as long a period as the human adult could survive without breathing. In the case of this subject no permanent aftereffects occurred, but one suspects that many infants are kept alive by this fundamental mechanism only to be damaged mental and neurological specimens thereafter.[12] This seems to be an example of how the species blindly tries to survive even at the expense of the full development of its individual members.

We know a few things about the way the infant raises the oxygenation of his arterial blood immediately after birth, and how this is sometimes accomplished without as much expansion of the lungs as might seem necessary. This shows that although the average newborn emerges from the uterus with his blood only about 50 per cent saturated with oxygen, within two or three hours thereafter (and sometimes within a very few minutes) this has been elevated by the baby's own efforts to the 90 to 95 per cent characteristic of adult life.[15]

We know not only that most newborns, (whether atelectatic or not) make this adjustment to new oxygen levels surprisingly well; we also know something of what respiration costs them in the way of muscular effort. And this is valuable knowledge to us because it indicates how much force should be used in devices for artificial resuscitation. To orient us in this matter it may be recalled that when a paralyzed adult or child is placed in a respirator because of intercostal and diaphragmatic poliomyelitis, the lungs usually respond nicely to a negative pressure of 12 to 14 cm. of water. But, as was shown by my predecessor, Dr. James Wilson, a force of this order is ordinarily insufficient to expand the lungs of a newly-born infant.[19] So strongly do the thousands of moist alveolar surfaces in an unexpanded lung adhere to one another that the first breath of an infant may require 20 to 25 cm. negative pressure in the pleural space. This, which may well be the most difficult inspiration he will have to make, will be made even more difficult if hemorrhage, edema, or aspiration of meconium and vernix has occurred before, during, or after delivery. Then forces equal to 30 or more cm. of water may be required to convert the lungs from a wet and heavy tissue to a buoyant mass of air-filled alveoli. How close is a negative intra-pleural pressure of 30 cm. H_2O to the neonatal infant's upper limit of thoracic exertion? Is there a comfortable margin of safety here, or are some infants caught in a physiological vice which requires respiratory effects beyond the capacity of

their ribs, diaphragm and intercostal muscles? Studies on well babies[14] have shown that most of them can produce intrathoracic negative pressures of 40 or even more cm. of water, but how much these powers are enfeebled in asphyxial states we do not know. Probably very much indeed. Therefore, there are times when some force must be artificially applied, and the investigations just quoted tell us not only that this may have to be 35 or more cm. water, but also that such forces are probably safe for artificial use since Nature equips the newborn infant with that much power for its unaided efforts.

One or two other points as to respiration are worth mentioning. One is that not all portions of the lung may normally expand during the first day of life nor even during the first week or two. In one series of several hundred normal infants studied roentgenologically, some primary atelectasis was still present in about 18 per cent of them at ten to fourteen days of age. This being the case, to say that an infant is sick with or dies of atelectasis is not a proper statement. He may indeed have large areas of unexpanded lung and even may suffer some detriment therefrom, but then our job is to find out the primary fault behind the persistent inability to expand the lungs, rather than to rest upon the fact as a sufficient explanation for symptoms.

Another intriguing attribute of respiration in early life—and this stems directly from the proportionately extensive surface areas of these patients—is the comparatively large *amount* of breathing which babies are called upon to do. The tidal air, or the average volume of one breath, of a 7.5 pound newborn infant is about 20 c.c. The tidal air of a 3- to 4-pound premature is about 12.5 c.c. Now the average full-term infant is about 1/20 the weight of a small adult, and the premature infant about 1/40 of the adult's weight. Let us, for the purpose of comparison with adults, multiply the respective tidal air volumes by 20 and 40, and we find that they become 400 and 500 c.c.—figures not far from the average adult value of 450 c.c. of air per breath. Thus far, these small subjects would seem to be exactly like minature adults. But recall that the adult breathes 18 times a minute, the full-term infant 44 times and the premature 58 times. This means that reduced to comparable size, the adult has a *minute volume* of respiration of $450 \times 18 = 8{,}100$ c.c., the full-term baby 17,600 c.c., and the premature infant $58 \times 500 =$ nearly 30,000. Reduced to standard size, then, the mature infant moves twice as much air and the premature over three times as much air per minute as the adult does. From this larger point of view, it becomes clear that the newborn not only has to adjust to a new form of life after his intra-uterine career, but that this life is not the same as the life of a miniature adult.

Studies by Stevenson[17] at New Haven have recently indicated a deficiency in carbonic anhydrase in the blood at birth, a deficiency especially severe in premature infants. This substance, carried in the red cells, is an enzyme which acts to increase the rate of conversion of bicarbonate to carbonic acid. Thus, it makes possible an efficient release of CO_2 into the lungs, and a concomitant acceleration of the rate at which the blood can take up oxygen there. Even in the presence of normal pulmonary ventilation and a sufficient amount of hemoglobin, the neonatal deficiency in carbonic anhydrase may be one reason for vague respiratory difficulties of the newborn which are (otherwise) unexplainably relieved by transfusions with adult blood.

Without leading the discussion into the finer details of the fetal circulation, one can still mention a few oddities of circulatory physiology which give a more informed approach to the peculiarities of newborn patients. Infants may not have been breathing for weeks or months before birth, but their hearts have been circulating blood not only around the body of the fetus but out to the placenta and back as well. Thus, there is abandoned at birth a yard or more of vascular channels and along with this a portion of the fetal blood volume which may amount to as high as 30 per cent of the pre-natal total. It is not surprising to find that the heart is of comparatively large size at birth and that it scarcely grows for some months thereafter, or does not grow as rapidly as the rest of the thorax and body. Indeed it may actually diminish a little in size for a week or so. Therefore ordinary rules as to cardio-thoracic ratios as shown in the x-ray simply do not apply in the roentgenology of newborn infants. Moreover, it is easily appreciated that any definite *increase* in cardiac size during the first week or two of life is of extreme diagnostic and prognostic significance as an indication of serious cardiac difficulty. In the electrocardiogram another peculiarity of new-

born physiology comes to light in the entirely normal presence of right ventricular preponderance for four weeks or so after birth, because right and left ventricles are more nearly of the same size and function in fetal life than afterwards.

Finally, the simplest clinical situation in which a physiological idiosyncracy may give perverted physical findings whose interpretation may be puzzling is that of a cardiac murmur in a newly-born patient. During a period of adjustment such as the heart undergoes at and after birth, an occasional murmur can well be expected. One author has said that murmurs occur in about 2 per cent of all newborns, another gives ten times that figure.[9,13] Obviously it depends on what one calls a murmur, but the important thing is that most of these adventitious sounds disappear with a few days of observation. Much more embarrassment to the clinician arises in the occasional reverse picture, in which a newborn infant's heart sounds normal a few hours post partum only to develop a significant murmur with progressive enlargement a few days later.

Perhaps a word about blood pressure may not be amiss if only to correct the erroneous figures which occur in the literature. Mistakes have been perpetuated by the use of improperly broad cuffs, so that only lately has it become known (a) that the proper cuff for determining the small infant's blood pressure is one inch broad, and (b) that under these circumstances newborn infants have blood pressures which rise from about 75/40 at birth to 95/50 at four days—figures which are much above those often quoted.[11]

The *blood* of the newborn goes through a series of changes pretty well known to us all, but deserving mention on one or two points which sometimes cause confusion. The red count varies to an extraordinary degree, apparently without much regard to the maternal health or diet. These variations, which range in careful work on normal subjects from a low normal of less than four million r.b.c. per cu. mm. to a high of more than six million, are evidences of the extremely labile state of the bone marrow at this time. So also is the fact that a few mucleated red cells may be found normally in the first 24 hours or more after birth. Just how many erythroblasts are allowable normally is impossible to state, but probably as many as 10 per 100 w.b.c. may occasionally be encountered on the first day of extrauterine life without necessarily signifying the presence of erythroblastosis or infection.

But it is among the vagaries of the white count that really phenomenal swings occur. During both the immediately post-natal polymorphonuclear leucocytosis of 15 to 40,000 w.b.c. per cu. mm. and the succeeding period of lymphocytic increase, one may find the white count an extremely unreliable aid to specific diagnosis. Thus, Washburn[18] came to the conclusion that in quite normal babies under four months of age the total white count might be as low as 4,000 or as high as 23,000 without any connection with infection or any other disease process.

The physiological hypothrombinemia and the brilliant effectiveness of synthetic vitamin K preparations in controlling neonatal bleeding tendencies have been too well publicized to merit comment here, except to say that at the Children's in Boston and at the Children's in Detroit bleeding newborn infants, in whom or in whose mothers this preventative of hemorrhagic disease has not been exhibited, are still occasionally seen.

The *basal metabolism* of newborn and premature infants has been investigated sufficiently to show that by standards of body surface, which are the proper ones to use, neonatal basal metabolism is low.[2] The first few days are a time of comparatively sluggish life processes, and, especially in the premature, energy is being slowly consumed and slowly produced. One cannot read the work of Benedict and Talbot[2] and of Levine and Gordon and their colleagues[8] without a feeling that Nature does not want her newest human products to be run at the faster speeds of later life any more than does the automobile manufacturer recommend 40 miles an hour during the first 500 miles.

A by-product of metabolic studies upon the newborn is the knowledge of the metabolic mixture consumed, as shown by respiratory quotients. During the first few hours after birth, the R. Q. tells us that the infant is living on a metabolic mixture of about two-thirds carbohydrate and one-third fat. But from the end of the first twelve hours until well into the fourth day, the figures indicate an almost entire combustion of fat. The implication is that at birth a store of liver glycogen is available, but only a small one. When this is consumed the baby normally begins to draw upon the more lasting stores of body

fat, and to be sustained by this until the milk comes into the mother's breasts.

In the next few years we shall probably learn a good deal more about *renal function, water balance,* and *electrolyte economy* in neonatal life than we now know. We do know and should not forget that the first few days of life are normally a time of dehydration of the body—just as are all the later months of human fetal life. The embryo spends its career not only in growing but in drying out, and the newborn infant continues the process not only during the interval when he rests from growth after birth, but for some time thereafter. As to what is going on in his cells, intercellular fluids, and kidneys we are not well aware, but there are some hints available. A clinical one is that some and perhaps all newborns have a relative tendency to salt retention, displayed if their normal electrolyte pattern is interfered with by salt given them beyond a certain poorly-defined threshold level. Not so long ago, we saw infants with dehydration fever brought about by a too zealous dependence on what might be called the "root, hog, or die" principle of alimentation. Now we have too many infants admitted at a few days of life with obvious water-logging from too free usage of normal salt solution. We see prematures in our own wards whose hands and feet lose their lace-like quality to become pudgy with edema. And we see in obstetrical nurseries what sometimes happens to occasional infants who, after difficult and asphyxiating deliveries, are quiet, unresponsive, and a little dry, with sunken fontanelles and the inelastic skin failing to hide their cranial bone sutures. A little too free use of parenteral salt solution and some of these same infants go into convulsions from what may well be cerebral edema.

A start has been made by Gordon and others[6] in this country and by McCance and his colleagues in England,[10] in providing the knowledge that newborn infants and especially prematures are not equipped with kidneys able to perform so well as those of older children when it comes to delicate tests such as urea clearance. McCance has gone even further and stated that the newborn infant is unable to excrete a urine which is hypertonic when compared to his blood plasma. Were this true it would mean that the infant with edema would find it impossible to wash excess electrolytes from his body in order that unnecessary water might follow. Studies in which I had the privilege of working with Dr. Gamble just before I left Boston indicated to us that this was not true—for when we pushed salt intake high enough by mouth (or, I believe, by needle) there came a point at which even the newborn premature excreted a hypertonic urine, got rid of salt, and then was able to give up unnecessary water. Nevertheless, many infants who seem by the scales to be doing admirably will turn out on careful inspection to be retaining unhealthy water rather than healthy flesh or fat, and we have come to respect the probability that for certain reasons not yet clear the management of the newborn entails watchfulness for this factor.

Times does not permit a discussion of an *alimentary physiology,* but I would like to make one point in that general field. The newborn infant is a complete novice when it comes to the digestion and absorption of food. His heart has been beating for months *in utero* and he may even have taken some practice swings in the way of respiratory effort, but he has not yet absorbed any food from his intestinal mucosa. Nevertheless, by the end of fourteen days or less, he has to handle perhaps 18 ounces of milk. Since he is about 1/25 as big as an adult, this means that he carries on a digestive effort which would be equivalent to the consumption by one of us of $18 \times 25 = 450$ ounces, or something like 14 quarts of milk daily. The implied difficulty in making such a performance within two weeks after starting from scratch is a rough but striking reason why it behooves us to use care in the way we feed him. Investigation by anatomists and roentgenologists, especially Henderson's[7] recent and careful studies from Pittsburgh, have shown that the mechanical basis for this astonishing acquisition of digestive skill is an alimentary tract characterized by an abundance of absorptive cells and secreting glands, but a comparatively thin and easily relaxed muscle wall. Distention is easily brought about; topographical relations vary tremendously with the amount of food and of air contained in the stomach and bowel. Food moves slowly out of the stomach (some of a feeding often remaining there for more than 8 hours) and slowly down the upper bowel, to attain speed as the colon is reached. Thus the newborn infant transports a barium-containing feeding more slowly from esophagus to colon than does an adult, while the colon, on the contrary, is emptied

of its newly-arrived contents much more quickly than in later life. Overloading of the stomach and diarrhea are easily produced in such an organism.

These are only a few of the physiological peculiarities of the newborn. The territory of icterus neonatorum, so carefully mapped out by Dr. Weech and his colleagues,[4] the fields of endocrinology and neurology, and many others are beyond our time limits today.

The whole subject of neonatal physiology, interesting for its own sake, also offers us suggestions for the management of well babies and the therapy of ill ones. From respiratory physiology we learn something of the importance of oxygen supply even for babies not in obvious distress, of seeking causes behind atelectasis, of unsuspected advantages that may be brought by the transfusion of adult blood, and of what we are trying to do in the application of resuscitating devices. From circulatory physiology and hematology we derive diagnostic information with both positive and negative implications. From metabolism, excreatory, and digestive studies we get hints that our patients in obstetrical nurseries should not be loaded with calories, minerals, or water beyond the amounts Nature seems to have designed them to handle. We get hints by watching these patients themselves as to what they need in order to make the easiest use of their special aptitudes and inaptitudes, and we get a sense that these are a safer set of indications for our guidance than an arbitrary line on a weight chart. After all, the most successful handling of these patients in their pre-natal life by our obstetrical colleagues has alway been one of respectful and unobtrusive assistance to Nature. Physiological knowledge of neonatal life should help us carry on a course based on a similar fundamental philosophy.

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MSMS

Poliomyelitis: Contrast Between the Kenny and Orthodox Concepts with Results of Treatment

By Sister Elizabeth Kenny
Minneapolis, Minnesota



Originator of Kenny Method of treatment for poliomyelitis; Honorary Director of Elizabeth Kenny Institute, Minneapolis.

Infantile paralysis has been regarded in the past as a disease causing muscles of the body to become hypotonic and flaccid. Treatment for such condition was to rest the supposedly affected muscles by the application of splints and casts. On the contrary the muscles affected by the disease of infantile paralysis are hyperirritable and in spasm. The toneless and supposedly paralyzed muscles are the normal muscles. It is obvious that the true symptoms of the disease are quite the reverse from that of the previous conception. It follows that a treatment devised for flaccid paralysis could not be adapted to a disease in which the muscles have the averse condition or spasm of the muscles. Spasm is the damaging condition in acute infantile paralysis. Spasm in muscle precedes paralysis and causes destruction of muscles, shortening of muscles, and eventually produces deformities. Treatment properly designed and instituted early will prevent undesirable after-effects.

■ In presenting this paper I shall endeavor to describe as far as possible the history of the work in the United States.

Presented at the Third Annual Conference on War Medicine, the Seventy-eighth Annual Session of the Michigan State Medical Society, Detroit, September 24, 1943.

It is now three years since the Public Welfare Board of the city of Minneapolis provided accommodation in the City Hospital for an investigation into the concept and treatment of the disease Infantile Paralysis, according to my views of this disease. This procedure has been arranged by Dr. Wallace Cole, Professor of Orthopedic Surgery, University of Minnesota. This step was taken by Dr. Cole after having witnessed satisfactory improvement in cases that had failed to respond to orthodox treatment and certain deformities corrected in the same patients. Similar happenings had been experienced by Dr. Miland Knapp, Professor of Physical Therapy, University of Minnesota, with a patient of his that had failed to respond to the best orthodox treatment for several months.

At the onset it was very difficult to secure a sympathetic audience. This can well be understood when it is realized my first presentation was the absolute abandonment of the paramount principle of treatment in this disease according to orthodoxy—that is, immobilization by splints, casts or frames. I was greeted with much ridicule and argument at the mere suggestion of such a thing. I was asked if I had ever seen the gross deformities in the children coming from centers where the neglect of this procedure had been practiced, and much more. The assembled group were doctors and physiotherapists, trained in the leading schools of the United States and had practiced at the leading centers of treatment in New York, Boston, Baltimore, Washington, Georgia Warm Springs, Mayo Clinic and many other centers.

My reply to this question was a reference to the fact that I was invited to remain amongst them, partly by the fact that I had demonstrated to Drs. Knapp and Cole that immobilization could be abandoned and Kenny treatment given and deformities corrected that had materialized during orthodox treatment; also, function could be restored in muscles that had failed to respond to the best orthodox technique. Also, it was admitted by the London Committee that they would have to admit that my abandonment of immobilization had not brought about any disaster nor was there any delay in the initial return of power. Again, the Committee reporting on the work during the drastic epidemic in Victoria, Australia, 1937-38, stated that the expected deformities from muscle imbalance had not materialized in the patients treated under my supervision but had materialized in their own splinted patients they, themselves, treated or received from other surgeons. They also admitted that stiffness was a troublesome feature in the patients they had treated and entirely absent in the patients under my supervision and added, "The reason why should be earnestly sought." They further stated, "Miss Kenny lays great stress upon the condition of muscle spasm, its prevention and cure. We consider her views upon this subject require careful consideration." Consequently to the logical mind there must be some reason why these things happened on the one hand and were entirely absent on the other. This reason required investigation.

We shall consider the symptoms first for which immobilization was supposed to be the paramount principle of treatment. For this presentation we shall take *Public Health Bulletin,* No. 242, presented to me by the National Foundation for Infantile Paralysis as the accepted textbook of that Institution. This work was compiled by Florence P. and Henry O. Kendall, Children's Hospital School, Baltimore. In the foreword, written by Dr. George Bennett, the following statement is made:

> "The damaged nerve cells are in the cord inaccessible to any form of treatment. Their recovery being based on the character and degree of injury they have sustained. At this point appears the importance of the muscle. A tissue in no way directly attacked by the virus, but rendered as useless by its loss of innervation as an automobile with its battery stolen. The muscle undergoes certain degenerative changes, the most important of which is its loss of 'tone' or state of tension, so that instead of being taut and elastic, it is relaxed, easily stretched and sagging like a hammock between its points of origin and insertion."

This sagging muscle is supposed to be, according to orthodoxy, the denervated muscle—the muscle that has lost its tone and state of tension—and the opposing muscle is accepted as the normal muscle that is not in any way affected by the disease.

To overcome this condition and put the supposedly weak and flaccid muscles at rest, the patient is placed in splints, frames or plaster casts.

On page seven of this bulletin, it is stated:

> "If a single lapse in the protection of the weaker group against overstretching will set back the ultimate recovery of muscle function for months."

This protection and rest is supposed to be kept up without treatment until pain has been abolished. At the end of three or four weeks the patient is examined and if pain is still present the patient is put to rest for another period of weeks without treatment.

The evidence presented in this paper and appearing as a sad sequela wherever this disease has been evident in any country—that is, the materialization of deformity, despite their best efforts of splinting—would make one understand that there must be something lacking in the treatment, or that the treatment is given for symptoms that did not exist. The truth of this latter statement was the colossal task set before me, starting on that June day in the year of 1940.

My first effort was to prove that the orthodox theory or concept was wrong; therefore, the treatment evolved for this concept must certainly be wrong. From my own observations of this disease in the lonely bushland of Australia, the symptoms were just the opposite to that for which this text, *Public Health Bulletin,* No. 242, was written; and I was willing to demonstrate to the very earnest medical men interested, this new concept and treatment.

In the course of time the heads of the Orthopedic and Physical Therapy Departments of the Medical School, University of Minnesota, Drs. Cole and Knapp presented a report on their observations. This report stated that I had evolved an entirely original and unconventional concept of this disease, and stated:

> "According to this concept the cardinal symptoms of infantile paralysis are, to use her terms, muscle spasm, muscle incoördination and mental alienation. This is opposed to the usual concept where the cardinal symptom is flaccid paralysis without muscle spasm or incoördination."

This report states further that the symptoms acknowledged by me presented themselves in 100 per cent of the cases. Thus it will be seen that three years ago it was admitted that the result of my research was of the greatest importance to all mankind. The observers at Minneapolis had an answer to the reason why. Deformities and stiffness had not developed in the patients treated under my supervision in London, England, and Melbourne, Australia; also, why deformities had been corrected and function restored to patients in Minneapolis when orthodoxy had been abolished and Kenny substituted. The one treatment had been evolved for symptoms that did not exist and the other for the true symptoms of the disease.

However, it was not until the year 1942 that prominent orthopedic surgeons and teachers of physical therapy at prominent schools came to the physicians' classes at Minneapolis. I am happy to say that although they came in doubt (and some admit they came to jeer and went away to cheer) they all went away satisfied that I had made a great contribution to medicine. Over one hundred of these gentlemen voluntarily signed a statement that I had presented to them a new concept and led them along a new pathway of treatment and that their earnest wish was that I should live to see the day my work would be established throughout the world. Also, one very outstanding member of the medical profession who in my early history was most antagonistic admitted that not only had I made a great contribution to medicine, but I had made the greatest contribution the world has ever known to physical therapy.

This statement brings me to a very important department of my work—that is, the correct treatment for the true symptoms of this disease. Some short time ago a group of workers tested out the several modifications of orthodox treatment for the orthdox concept. It was found that a higher percentage of recoveries had been registered when the patients were left without treatment. The results of this test were published in the *Journal of Bone and Joint Surgery,* October, 1941. The highest percentage of restoration to normal by any type of orthodox treatment was 13 per cent and the percentage of normal recoveries, or supposed normal recoveries, was 17 per cent when the patient did not receive any treatment. It is only logical to understand if the treatment given produces less recoveries than when no type of treatment has been given that that treatment is harmful and must aggravate the symptoms rather than help them recover.

The best indication of the value of the treatment for the symptoms of the disease as presented by me is the fact that during the past three years no child in the city of Minneapolis who has suffered from this disease has had to be admitted to the Crippled Children's School, and when the work is carried out in its entirety at the

Elizabeth Kenny Institute, the percentage of recoveries is 87.4 per cent. Prior to the introduction of the Kenny Method of treatment for the Kenny Concept, 26 per cent of the cases had to be admitted to the Crippled Children's School. The enrollment at this school from this disease was previously 100. The 87.4 per cent normal recoveries are usually obtained from three to nine months from the onset. We have presented to the 267 doctors who have attended the physician's classes patients who have made a complete and satisfactory recovery at the end of three months.

We have also admitted to the Institute patients comparable to the above-mentioned who have received from 18 months' to seven years' orthodox treatment and still remain hopeless cripples owing to the fact that the true symptoms of the disease have not been treated. This comparison has been admitted to be just and fair by prominent members of the medical profession. These unfortunate little children are doomed to a life of disappointment and handicap owing to this lack of knowledge. It can well be understood that the symptoms that have escaped the notice of the medical world down through the ages are not easy to overcome. This is especially true when the operator has been working for years from the opposing angle. It takes a minute understanding to be able to carefully carry out muscle analysis and treat the muscle in spasm and gently nurse it back to health, to restore the muscle sense to the alienated muscle and give back to it the correct pattern of action and restore the brain path.

I was asked by Drs. Cole and Knapp upon my arrival in Minneapolis how long it took to train a teacher in this work. I replied it usually took two years in Australia. These gentlemen admitted that the more they saw of this work the more they understood this statement. I regret to say that it is in this respect the United States has failed desperately. Although I repeatedly emphasized this fact, no effort has been made to see that the suitable people are trained to become teachers upon my retirement. Classes have been rushed through in order to spread the knowledge. The students have returned to their centers in the United States and have given entire satisfaction to their medical supervisors but have failed in the art of teaching the method to others. This failure has been brought about by the fact that the student has not been associated with the work long enough to become familiar with the disease in all its aspects and also familiar with the revised physical therapy and science of kinesiology as taught at the University of Minnesota and the Elizabeth Kenny Institute. Training centers have been opened and closed and others opened, which, to my thinking, is a waste of valuable time. A selected number of teachers should be sent to Minneapolis and kept there until they are fully qualified to teach the work in its entirety.

Observations

It is over thirty years since I first saw the symptoms described above. Ten years ago I endeavored to present to a group of medical men in Brisbane, Queensland, Australia, this concept. I was requested to present to the assembly my observations of the disease. I commenced to grant the request and stated the first thing I asked a child to do is attempt to sit up. Invariably they cannot. I then investigated the reason why and found that the muscles on the posterior neck had shortened, pulling the head backward and thus preventing forward flexion. I also noticed an exaggerated groove starting at the base of the skull. This statement was greeted with loud jeering laughter. The world at this time accepted this condition as the result of meningeal irritation or inflammation. However, four years later full acknowledgement was given of this condition of muscle spasm at the same hospital; also of the condition or symptom of incoördination and alienation. And so out of the darkness that had surrounded this disease for centuries, a ray of light was borne, and in order to fan this light into a flame of hope I visited the United States of America; and to many hundreds of members of the medical world I have presented and proved the existence of these symptoms and conditions and the satisfactory treatment evolved for these symptoms.

I also had the honor of being appointed Special Guest Instructor at the University of Minnesota and New York. I have been associated with the University of Minnsota for over two years and the University of New York for almost one year, and up to date have not had the opportunity of presenting to the heads of the departments of Neurology, Physiology, Anatomy, Orthopædic Surgery, and Pediatrics my further observations of this disease. Therefore,

I think this honor of doubtful value. The time is fast slipping away, and I have waited in vain for this opportunity. Consequently, I will have to run the gantlet of further criticism and present to the present assembly my further observations, and they can be taken for what they are worth.

In the first place my observations have been restricted to the soft tissue of the body. The chemical and neurological aspect of the disease is out of my province, but what happens to the muscles from observation from the periphery is, to me, almost like an open book. When a patient is admitted to a hospital and definite diagnosis given, I have found the disease has already started its ravages. To one unaccustomed, the patient may just be a sick child, and the medical observer may be just waiting to see where paralysis may develop and, incidentally, confirm the diagnosis; or the patient may, after a given time, be sent home as an abortive case (in many cases only to return a few months or years later with commencement of deformities and the beginning of a long session of treatment); or it may be in a few days or hours the muscles will become very painful. The child will be immobilized and long months and possibly years of treatment lie ahead.

My observations have been that before pain or any sign of paralysis appears, there is a muscle condition present that will denote where pain, spasm or consequent paralysis is most likely to occur. This is why I have been most anxious to meet the heads of the departments, mentioned above, in order that I may demonstrate this condition. During my last visit to New York I was requested to examine a doctor's son who was suffering from this disease. I pointed out this muscle condition to a very prominent New York pediatrician to his entire satisfaction. I have also presented this condition to many medical men during my tours of inspection and with my associates in Minneapolis. Furthermore, I have explained to the medical observers in Minneapolis which muscles to expect the disease to present itself by the presence of pain and spasm—perhaps in a few hours or days—and have given advice what to do to help this particular muscle fight the enemy. Sometimes we are successful in preventing the spread of the condition and early combat the pain and preserve the muscle intact. Upon other occasions we have observed the muscle will be preserved and shall apparently function normally, but it will be observed that the normal contour has changed. Grooves and depressions shall be present, or the whole muscle belly may be narrowed. It may be thought that the cells controlling these particular segments are destroyed and the segments atrophied. However, when the special treatment designed for this condition is given and the shortened segments lengthened, it will be found that they will contract satisfactorily. It will also be found in a very high percentage of cases—more especially in the spinal group—when the whole muscle belly is narrowed and shortened and apparently completely paralyzed or nonfunctioning that when treatment is given for this condition, function is immediately restored. I have demonstrated this phenomena upon many occasions to many medical men.

I could go on further with many observations, but the question to be answered is (in view of the evidence submitted): What is really the primary seat of the trouble? Is it the muscle? the nerve? the cell? or the chemistry of the body? Does the virus go upward or downward? Why should a muscle present this peculiar condition before the patient presents any other diagnostic symptom—such as pain, spasm, incoördination, or alienation? Why should certain segments and sometimes the whole muscle belly be badly affected and apparently atrophied and paralyzed? Why should the muscle satisfactorily function when treatment is given for these conditions?

These are questions I have for a long time desired to ask the medical world. Many medical men have seen this phenomena. Understanding that it would be impossible to restore function if the cell was destroyed and yet function has been restored immediately the muscle condition has been attended would lead one to believe that the muscle has been more seriously affected than the cell.

The ravages of this disease and its sad sequelæ may be judged by the contents of a report submitted to the National Foundation for Infantile Paralysis by Dr. Philip Wilson, Medical Superintendent of the Hospital for Ruptured and Crippled, New York, in the year 1940. After explaining that although there were many crippling agencies—including accident, birth conditions and disease—poliomyelitis was responsible for one-third of the crippling of the total number. These statistics speak more eloquently

than any words of mine of the failure in the past to combat this disease, more especially when it is added to the evidence already recorded in this paper—that is, the fact that the enrollment at the crippled children's school in Minneapolis from this disease has been reduced to nil since the Kenny work has been introduced into this center. Also, the statistics at the Mayo Clinic record that reconstruction operations for the after-effects of this disease have fallen off during the past year. This statement brings me to the very important subject of treatment.

Treatment

Prior to my arrival in the United States, pool treatment was extensively used. This procedure for the previous concept would have been most desirable. However, for the treatment of the true symptoms of the disease—more especially in the acute stage—it is not only unnecessary but impractical. The Kenny method demands a more intimate and accurate knowledge of the science of muscle physiology and kinesiology. The treatment must be carried out under close observation in order to record if the symptoms and conditions have been partially or wholly overcome. It would be impossible to observe the true contour of the muscles in action under water, or restore the brain path in a satisfactory manner or control incoördination. It is also impossible to obtain complete relaxation of the whole bodily mechanics if any effort is put forth to maintain a stable position. The great importance of this procedure cannot be overestimated.

I have also been asked upon many occasions—What is the value of the drug prostigmine? My reply can best be recorded by the observation of Major Stone, Major Erickson of the U. S. Army and Dr. Todd of Washington. These three gentlemen returned for a refresher course to Minneapolis and during their observations asked me why three certain patients had not responded to treatment as well as the remaining group of equal severity. My only reply was that if they investigated, they would find that these three were the ones who had prostigmine treatment—the others had not. This fact was a disappointment to me, for I had hoped that an easier way could be found to combat the condition of muscle spasm.

Electrical testing of muscles is not desirable even under normal conditions. For instance, I was present when Dr. Moldaver tested by chronaxia the obliquus abdominus muscle of a male patient, aged ten years. All lower limb muscles in this patient were normal. However, it was found that after testing, the leg tested had an apparent shortening of two inches. This made it very awkward for the patient who was ambulatory. I suggested to Dr. Moldaver to shorten the right leg also, which he did. This removed the disability as far as walking was concerned, but the patient walked with a stoop. However, treatment was given for spasm and the patient could again stand erect. More than thirty members of the medical profession witnessed this procedure.

The theory that malnutrition or unsanitary surroundings may be the inducement of the onset of this disease is not supported by my observations. I have also noticed that the incidence of the disease occurs much more frequently in the white race per ratio of population—that is, in the United States and Australia. We have had a very small percentage of pure negro patients, (less than one per cent), and patients removed one or two generations from the negroes have not been met with at all by me in any country.

Another procedure to which those trained in orthodoxy technique cling to with tenacity is muscle testing. This procedure also prolonged treatment and debarred full recovery. When I made this remark to an orthopædic surgeon his reply was, "But how can we judge progress if we do not do muscle testing?" I instantly drew his attention to a report submitted by Dr. A. Deacon, Orthopædic Surgeon, Children's Hospital, Winnipeg. This report stated, "We were astounded to see Miss Kenny cause patients to use flaccid muscles, which we had observed to be totally paralyzed, merely by restoring the patient's mental awareness of those muscles, and thus correcting their alienation."

I have repeatedly done this in Minneapolis, New York, Chicago, Tulsa, and many other places. I shall now ask of what value was this record? Was it possible for me or any other person to restore anterior horn cells in the space of a few seconds? This alienation had persisted in some instances for a period of six years. Thus muscle testing was erroneous and misleading.

Those of your number who have visited Minneapolis have observed patients with muscle function in one lower extremity nil and yet the

(Continued on Page 716)

Your September Vacation

As your President, I want to extend to every member of the Michigan State Medical Society and to physicians of other states, a most cordial invitation to attend the 1944 Postgraduate Conference on War Medicine.

Doctor, you need a few days away from your busy practice where you can relax, meet many of your friends whom you have not seen, possibly since last year's meeting, and where at the same time, you can have the unusual opportunity of attending one of the most outstanding Postgraduate Conferences that your State Society has ever sponsored.

It would be presumptuous for me to try to tell you the value of postgraduate medical education. You know and I know that to keep abreast of the rapidly-developing and ever-changing science of medicine, we must look to postgraduate education.

Plan now to so arrange your work that you can attend the Annual Scientific Session of your State Society at Grand Rapids on September 27, 28 and 29.

C. R. Keyport

President, Michigan State Medical Society

President's



Page

EDITORIAL

PUBLIC OPINION

■ Surveys of public opinion have become standard practice before undertaking revolutionary or even very important projects. Such a survey and what the people think of medicine, private practice, or prepayment plans has recently been completed in California, and one is being made in Michigan. Our survey will not be completed until later in the year, but California gives us a preview, and the trends developed are challenging. The report covers 232 mimeographed pages and points some lessons we may well ponder in Michigan.

An interpretative report deals with "the one major issue; Federal Medicine":

"We want to show you what you MUST do to meet this threat. We do not delude ourselves that you will like our recommendations. We give them as you would give a prescription to a patient, i.e., with the hope that it will be accepted as a considered judgment of an expert; with a prayer that instructions will be followed; and with the knowledge that if they are, relief may be expected logically to follow."

"One of the heart-warming elements of the survey is the high opinion in which most citizens hold the profession of medicine. It is because of this high opinion . . . that the profession, as such, has no desperate public relations problem. This is indicated by two facts: 80 per cent of the citizens would advise young men to study medicine; 88 per cent think the majority of doctors are doing a good job for the people. An amazing index of approval."

But in spite of this approval only 34 per cent of our citizens are against federal medicine, 50 per cent are in favor of it and 16 per cent have not made up their minds. Even if all the 16 per cent "don't know" voters were convinced, there would be a majority for Federalization, and the issue is lost. All groups from professional to unskilled labor show percentages of 36 to 56 for federal medicine.

The survey asks why there is such a demand for federal medicine when there is such high approval of the profession. The answer is given and proved. The people believe that the cost of scientific medicine is too high, and the people do not generally believe it has to be so. Percentages are given showing various objections as to cost, adding up to 72 per cent. The rest of the reasons given leave the distinct impression that cost is practically the whole reason.

Federal medicine is being nurtured by the seemingly high cost of private medicine today, but it is not just the cost of the doctor that irks people; hospital charges, nurses' fees, doctors' prescriptions and other costs irk them also.

When something is needed by all the people, but is too costly for many of them it is usually socialized so it will be available to all. Many believe quite evidently that medicine should be a public utility under government operation like the postal system.

The solution is apparent. To quote the report:

"To save free enterprise in medicine, it is necessary to provide scientific medicine THROUGH free enterprise in a manner which will make it readily and economically available to all the people all the time."

The survey analyst recommends:

(1) "that the Medical Association recognize the fact that federal medicine has swollen into a tide which is sweeping the public before it, that rather than defensively obstructing, the profession prepare itself to ride with the tide; and that it do this by using a prepayment medical plan set up by the medical profession and developed along the best lines so that it can function as a substitute for federal medicine; and in that manner it may wean away from federal medicine the majority of its electorate."

"The concept of California Physicians' Service is masterful. But your failure to promote it with an expertly designed and constructed plan is nothing less than tragic. . . . It could have long since served as a model for other state medical associations. . . . And had it done so, the issue of federal medicine might well not be confronting us at this time."

The survey analyst recommends:

(2) "that the California Medical Association refine C.P.S. so that it will be more acceptable to the general membership, that this be done without increasing the rate to the subscriber, which should be reduced if anything; and upon points which cannot be compromised, the membership be persuaded through proper methods to accept the sacrifices necessary."

The survey analyst recommends:

(3) "that a campaign of education on C.P.S. be immediately instituted for the membership of the Association, in both the objectives and the opportunities of C.P.S.; that the membership become sympathetic to the methods and reasons for their use; and above all that it be educated to the principle that a subscriber to C.P.S. deserves all the consideration of a private practice patient, and that any discrimination of a subscriber is simply an invitation to that subscriber to embrace federal medicine."

The fourth and final recommendation is:

"that all possible speed be made to conform to recommendations two and three, and that every effort be made aggressively to induce other State Medical Associations to start similar organizations now. The time is very short, the recommendations difficult to quickly consummate, but, if the fight isn't made, the battle is lost. So far as we can see there is no other hope on the horizon."

Michigan is now especially interested. We believe we have in *Michigan Medical Service* a potentially satisfactory substitute for federal medicine. But we have also a proposed State Constitutional amendment* that may prove even more threatening than federal medicine. It is consummately planned, and could be put through much easier than could any legislative enactment.

Michigan Medical Service is studying this report, is planning expansions of its services, and confidently expects to deserve and to get the united support of the membership of Michigan State Medical Society, without which it will fail, but with which it may well stay Federal Medicine as it has in the past few years.

In a few months we shall have our own survey ready from which we hope to derive valuable guidance, but until that time it behooves us to profit by what is available.

1944 POSTGRADUATE CONFERENCE ON WAR MEDICINE

■ The seventy-ninth annual session of the Michigan State Medical Society will be up to the high quality standard of past years. Preliminary announcements are made in this issue, and we call your attention to them.

This is a meeting that we cannot afford to miss. We are all working to the point of exhaustion, and need a little relaxation. Attendance at a medical meeting cannot be called a vacation, but certainly is a change in the everlasting grind, and gives us a chance to rub shoulders with our friends and colleagues. Nothing is more stimulating to greater efforts, or to better attainments.

These outstanding names should prove the value of this year's Conference on War Medicine. Gen. C. C. Hillman, M.C., Washington, D. C., Geza DeTakats, M.D., Chicago; Earl D. Osborne, M.D., Buffalo; Robert A. Moore, M.D., St. Louis, Mo.; Tom D. Spies, M.D., Cincinnati; John Wharton Harris, M.D., Madison, Wis.; Arthur W. Proetz, M.D., St. Louis, Mo.; Max M. Zinninger, M.D., Cincinnati; A. D. Ruedemann, M.D., Cleveland; Joseph L. Baer, M.D., Chicago; E. A. Rovenstine, M.D., New York; Frank M. Krusen, M.D., Rochester, Minn.; Herman E. Hilleboe, M.D., Bethesda, Md.; Major Frank H. Mayfield, M.D., Battle Creek; Col. Wm. C. Menninger, M.C., Washington, D. C.; Sidney Farber, M.D., Boston; S. Wm. Becker, M.D., Chicago; Jonathan C. Meakins, M.D., Montreal; Frederick H. Falls, M.D., Chicago; James L. Wilson, M.D., New York.

If you have not made reservations, do so now, and plan to stay to see the whole program through. It will do you good, and will in the long run be of outstanding benefit to your patients, so much so that they will be willing to have you attend.

ON THE RUN . . .

The cachexia of carcinoma may be merely the result of a gradual reduction of caloric intake rather than of a toxemia originating from tumor cells.

Osseous metastases from cancer of the breast may regress or disappear after ovarian sterilization.

Subfascia lata infusions of saline and 5 per cent glucose offer less discomfort, swelling and pain with increased rate of absorption and safety.

A nonhemolytic streptococcus, antigenically related to streptococcus salivarious I, has been found the dominant organism in about half of a group of patients with primary atypical pneumonia.

Gonococcal endocarditis is uninfluenced by penicillin.

Liquid blood plasma stored for more than a year produces a lower percentage of reactions than does dried plasma.

Aviator's "bends" are brought on more quickly by a straining exercise, the pains localizing in the joints used most.

Coagulability of the blood may be increased markedly in normal patients by as little as three days of bed rest.

Tubercle bacilli (bovine) are rapidly killed in fifteen minutes when stirred in propylene or triethylene glycol.

Bottled milk exposed to sunlight for one to three hours may lose between 40 to 72 per cent of its riboflavin content.

—Selected by Wm.. S. Reveno, M.D.

*Mentioned briefly, editorially in July Journal. See extracts of the proposed Amendment on page 632, Political Medicine.

Michigan State Medical Society

Past Presidents 1866-1942

1866—*C. M. Stockwell, Port Huron
1867—*J. H. Jerome, Saginaw
1868—*Wm. H. DeCamp, Grand Rapids
1869—*Richard Inglis, Detroit
1870—*I. H. Bartholomew, Lansing
1871—*H. O. Hitchcock, Kalamazoo
1872—*Alonzo B. Palmer, Ann Arbor
1873—*E. W. Jenk, Detroit
1874—*R. C. Kedzie, Lansing
1875—*Wm. Brodie, Detroit
1876—*Abram Sager, Ann Arbor
1877—*Foster Pratt, Kalamazoo
1878—*Ed. Cox, Battle Creek
1879—*George K. Johnson, Grand Rapids
1880—*J. R. Thomas, Bay City
1881—*J. H. Jerome, Saginaw
1882—*Geo. W. Topping, DeWitt
1883—*A. F. Whelan, Hillsdale
1884—*Donald Maclean, Detroit
1885—*E. P. Christian, Wyandotte
1886—*Charles Shepard, Grand Rapids
1887—*T. A. McGraw, Detroit
1888—*S. S. French, Battle Creek
1889—*G. E. Frothingham, Detroit
1890—*L. W. Bliss, Saginaw
1891—*George E. Ranney, Lansing
1892—*Charles J. Lundy (died before taking office)
*Gilbert V. Chamberlain, Flint, Acting President
1893—*Eugene Boise, Grand Rapids
1894—*Henry O. Walker, Detroit
1895—*Victor C. Vaughan, Ann Arbor
1896—*Hugh McColl, Lapeer
1897—*Joseph B. Griswold, Grand Rapids
1898—*Ernest L. Shurly, Detroit
1899—*A. W. Alvord, Battle Creek
1900—*P. D. Patterson, Charlotte
1901—*Leartus Connor, Detroit
1902—*A. E. Bulson, Jackson
1903—*Wm. F. Breakey, Ann Arbor
1904—*B. D. Harison, Sault Ste. Marie
1905—*David Inglis, Detroit
1906—*Charles B. Stockwell, Port Huron
1907—*Hermon Ostrander, Kalamazoo
1908—*A. F. Lawbaugh, Calumet
1909—*J. H. Carstens, Detroit
1910—*C. B. Burr, Flint
1911—*D. Emmett Welsh, Grand Rapids
1912—*Wm. H. Sawyer, Hillsdale
1913—*Guy L. Kiefer, Detroit
1914—*Reuben Peterson, Ann Arbor
1915—*A. W. Hornbogen, Marquette
1916— Andrew P. Biddle, Detroit
1917— Andrew P. Biddle, Detroit
1918— Arthur M. Hume, Owosso
1919—*Charles H. Baker, Bay City
1920—*Angus McLean, Detroit
1921—*Wm. J. Kay, Lapeer
1922—*W. T. Dodge, Big Rapids
1923—*Guy L. Connor, Detroit
1924—*C. C. Clancy, Port Huron
1925—*Cyrenus G. Darling, Ann Arbor
1926— J. B. Jackson, Kalamazoo
1927— Herbert E. Randall, Flint
1928— Louis J. Hirschman, Detroit
1929— J. D. Brook, Grandville
1930—*Ray C. Stone, Battle Creek
1931—*Carl F. Moll, Flint
1932— J. Milton Robb, Detroit
1933—*George LeFevre, Muskegon
1934—*R. R. Smith, Grand Rapids
1935— Grover C. Penberthy, Detroit
1936— Henry E. Perry, Newberry
1937— Henry Cook, Flint
1938— Henry A. Luce, Detroit
1939— Burton R. Corbus, Grand Rapids
1940— Paul R. Urmston, Bay City
1941— Henry R. Carstens, Detroit
1942—H. H. Cummings, Ann Arbor

*Deceased.

OUTLINE OF 1944 POSTGRADUATE CONFERENCE ON WAR MEDICINE

79th Annual Session, Michigan State Medical Society
Grand Rapids, September, 1944

	Wednesday September 27, 1944	Thursday September 28, 1944	Friday September 29, 1944
A.M. 9:30 to 10:00	General Practice GEN. C. C. HILLMAN, MC Washington, D. C. (Tropical Medicine)	Surgery MAX M. ZINNINGER, M.D. Cincinnati, O.	Medicine A. A. APPLEBAUM, M.D. Toledo, Ohio
10:00 to 10:30	Surgery GEZA DeTAKATS, M.D. Chicago, Ill.	Ophthalmology A. D. RUEDEMANN, M.D. Cleveland, O.	General Practice COL. WM. C. MENNINGER, MC Washington, D. C. (Neuro-psychiatry)
10:30 to 11:00	Dermatology EARL D. OSBORNE, M.D. Buffalo, N. Y.	Obstetrics JOSEPH L. BAER, M.D. Chicago, Ill.	Pediatrics SIDNEY FARBER, M.D. Boston, Mass.
11:00 to 11:30	Pathology ROBERT A. MOORE, M.D. St. Louis, Mo.	Anesthesia E. A. ROVENSTINE, M.D. New York, N. Y.	Dermatology S. WM. BECKER, M.D. Chicago, Ill.
11:30 to 12 Noon	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS
P.M. 12:00 to 1:30	*Three Section Meetings* Otolaryngology Pathology General Practice	*Four Section Meetings* Surgery Ophthalmology Obstetrics and Gynecology Anesthesia	*Three Section Meetings* Medicine Dermatology Pediatrics
1:30 to 2:00	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS
2:00 to 2:30	Medicine TOM D. SPIES, M.D. Cincinnati, O.	Industrial Health FRANK H. KRUSEN, M.D. Rochester, Minn.	Medicine JONATHAN C. MEAKINS, M.D. Montreal, Quebec
2:30 to 3:00	Obstetrics JOHN WHARTON HARRIS, M.D. Madison, Wis.	Medicine (T.B.) HERMAN E. HILLEBOE, M.D. Bethesda, Md.	Obstetrics FREDERICK H. FALLS, M.D. Chicago, Ill.
3:00 to 3:30	Otolaryngology ARTHUR W. PROETZ, M.D. St. Louis, Mo.	Surgery MAJOR FRANK H. MAYFIELD, MC Battle Creek, Mich.	Pediatrics JAMES L. WILSON, M.D. New York, N. Y.
3:30 to 4:00	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS	
4:00 to 5:00	DISCUSSION CONFERENCES with guest essayists	DISCUSSION CONFERENCES with guest essayists	DISCUSSION CONFERENCES with guest essayists
5:00 to 6:00	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS	END OF CONVENTION
8:30 to 10:00	OFFICERS' NIGHT Biddle Oration PRESTON BRADLEY, LL.D., D.D. Chicago	STATE SOCIETY NIGHT R. L. NOVY, M.D., Detroit, Mich. JOHN F. HUNT, M.D. Chicago, Ill.	

An Invitation

to YOU

Doctor, you are urgently invited to attend the 1944 Postgraduate Conference on War Medicine to be held at the Civic Auditorium, Grand Rapids, Wednesday, Thursday, Friday, September 27, 28, 29.

The Conference will cover the entire field of medicine and present those modern diagnostic and therapeutic agents, which, when used in your daily practice, will shorten your labors materially.

These stars in the medical firmament have important information on the practice of medicine in wartime—messages that will CONSERVE YOUR TIME by aiding you to recognize disease quickly and to use the most modern therapy.

Wednesday: *General Hillman, *De-Takats, *Osborne, *Moore, *Spies, *Harris, *Proetz, *Captain Frisch, *Preston Bradley.

Thursday: *Zinninger, *Ruedemann, *Baer, *Rovenstine, *Krusen, *Hilleboe, *Major Mayfield *Hunt, *Novy.

Friday: *Applebaum, *Col. Menninger, Farber, *Becker, *Meakins, *Falls, *Wilson, *Aldrich, *Curtis, *Clark.

Daily Quiz Periods have been arranged so you may discuss your cases with the guest essayists. Two postgraduate credits will be gained by attending the Conference.

Three days in Grand Rapids—September 27, 28, 29—will save you weeks of study, research, doubt and worry. They will make unnecessary your traveling all over the country for a wealth of scientific information.

Fraternally yours,

C. R. KEYPORT,

President, MSMS

——Committee Reports——

ANNUAL REPORT OF MSMS REPRESENTATIVES TO THE JOINT COMMITTEE ON HEALTH EDUCATION, 1943-44

The Joint Committee on Health Education has not been as active as usual this year. A few lay talks have been given through the Extension Division, but fewer than usual.

There has been one meeting of the committee, at which time the chairman presented a suggestion for an educational program consisting of presentations to the laity showing the various medical activities in the State. It was thought that such a program might serve as something of an antidote to the propaganda for government-controlled medicine. This suggestion, while it was approved by the committee, has not, as yet, taken concrete form.

Respectfully submitted,
BURTON R. CORBUS, M.D., *Chairman*
HENRY A. LUCE, M.D.
ROBT. H. FRASER, M.D.
F. J. O'DONNELL, M.D.
W. R. VAUGHAN, M.D.

ANNUAL REPORT OF PREVENTIVE MEDICINE COMMITTEE, 1943-44

Only one meeting was held by this Committee during the past year, and that for the purpose of reviewing and summarizing the activities of the Advisory Committees.

While individual reports of these Committees appear in this publication, certain accomplishments and actions are deserving of mention:

The highly successful Second Annual Conference on Industrial Medicine and Surgery.

Publication and distribution of a Cancer Manual.

Formulation of a program designed to bring material on "premarital instruction" to the attention of the profession.

A proposed program for a five-year study of maternal mortality in Michigan.

A graduate program on venereal diseases for the Upper Peninsula.

The above represents all too briefly the great amount of valuable time and coöperative effort contributed by the Advisory Chairmen and their Committee Members in the interest of the public and the Society Members.

Respectfully submitted,
WILLIAM S. REVENO, M.D., *Chairman*
JOHN BARNWELL, M.D.
L. O. GEIB, M.D.
WM. A. HYLAND, M.D.
K. E. MARKUSON, M.D.
F. B. MINER, M.D.
H. H. RIECKER, M.D.
L. W. SHAFFER, M.D.
C. E. TOSHACH, M.D.
FRANK VAN SCHOICK, M.D.
R. W. WAGGONER, M.D.

ANNUAL REPORT OF MATERNAL HEALTH COMMITTEE, 1943-44

Several meetings of the Maternal Health Committee were held during the year.

Following the publication of the report on maternal homes and hospitals, it was recommended to The Council that the Legislative Committee endeavor to have the registration of maternal homes and hospitals come under the supervision of the Michigan Department of Health instead of the Michigan Social Welfare Depart-

ment. Under the Health Department they will receive the supervision required for better obstetrical care.

The rules and regulations of the maternal homes and hospitals coming under the Emergency Maternal and Infant Care Program formulated by the Department of Health were approved by the committee and forwarded to the Executive Committee of The Council.

It has been proposed that a five-year maternal mortality study be conducted by the Maternal Health Committee of the Michigan State Medical Society. A sponsor has this project under consideration. It will be necessary to have complete coöperation of all of the doctors of the Michigan State Medical Society and all of the hospitals and maternal homes in the State of Michigan to conduct this study. Further information concerning this study will be given at the MSMS Annual Session.

Respectfully submitted,
Clarence E. Toshach, M.D., *Chairman*
A. E. Catherwood, M.D.
E. N. D'Alcorn, M.D.
Harold Henderson, M.D.
N. F. Miller, M.D.
Harold W. Wiley, M.D.
Alexander M. Campbell, M.D.

ANNUAL REPORT OF THE COMMITTEE ON PRELICENSURE MEDICAL EDUCATION, 1943-44

Two attempts were made to hold a meeting of this Committee during the past year, but without success.

Inasmuch as we desired very much to have the Committee's recommendations to present to the Michigan State Board of Registration in Medicine at its October session, letters were sent to each individual member requesting his opinion concerning the shortening of the twelve months' rotating internship as a war measure. The consensus of replies was that the Committee believed this action to be undesirable from an educational standpoint and that nine months' service did not give an intern adequate training—that if the State Board of Registration in Medicine saw fit to reduce the period of internship at its October session, it should be done only as a temporary war measure. Of course after the Surgeons General of the Army and Navy issued their ultimatum ordering into military service all interns upon completion of nine months' training and the State Board of Registration in Medicine had officially acted upon the matter, there was nothing further that interns or this Committee could do and a meeting of the Committee would have been futile. No action can be taken by this Committee until the present war is concluded.

Respectfully submitted.
J. Earl McIntyre, M.D., *Chairman*
Edgar H. Norris, M.D.
A. C. Furstenberg, M.D.
Donald C. Beaver, M.D.
George Curry, M.D.

ANNUAL REPORT OF THE COMMITTEE ON DISTRIBUTION OF MEDICAL CARE AND OF THE TEMPORARY COMMITTEE OF THE MICHIGAN STATE MEDICAL SOCIETY AND THE UAW-CIO, 1943-44

One meeting of this committee was held on November 16, 1943. There were five members representing the Michigan State Medical Society and ten members representing the UAW-CIO, six being regular members and four alternates.

The following resolution was adopted: "Whereas, at a meeting of representatives of the UAW-CIO and of the Michigan State Medical Society being held November 16, 1943, to discuss matters of common interest to the UAW-CIO and the medical profession, it is mutually agreed that: The discussions are predicated on a system of medical practice based on the philosophy of rights of free citizenship and the representatives of both parties are further mutually agreed that they are opposed to the forceful regimentation of both patients and doctors of medicine, we recommend that a permanent committee be provided of six members and alternates from the MSMS and six members and six alternates from the UAW-CIO for the transaction of medical business concerning the interests of the two organizations."

The Committee made recommendations as follows:

1. That a joint committee be appointed to edit the publication of a Health Column in the UAW-CIO newspapers and the journals of the State and County Medical Societies on matters of interest to the workers regarding public health and medicine.
2. That there be compiled a list of specialists that might be used for referrals of the UAW-CIO Medical Research Institute.
3. That a committee be appointed to meet with representatives of UAW-CIO, Local 50, Willow Run, to study the problems and make recommendations on the medical situation in that community.
4. That any proposed legislation affecting mutual interests of labor and medicine be referred to this committee.

James E. Davis, M.D., discussed what labor wanted from the medical profession and the position of the UAW-CIO Medical Research Institute.

There was a discussion by Mr. Marcus and others regarding the medical problems appearing before the Department of Labor and Industry.

General interest was expressed for some method to make decisions out of court on medical-industrial cases. No action was taken.

Complete minutes of this meeting have been submitted to The Council of the Michigan State Medical Society for their action. No meetings of the subcommittee with Local 50 have been obtained.

Respectfully submitted,
Committee on Distribution of Medical Care
R. L. Novy, *M.D., Chairman*
E. I. Carr, M.D.
A. F. Bliesmer, M.D.
R. H. Baker, M.D.
H. F. Dibble, M.D.
G. B. Saltonstall, M.D.
Wm. P. Woodworth, M.D.
Wm. R. Young, M.D.
H. B. Zemmer, M.D.
R. H. Pino, M.D.

* * *

Temporary Committee of the Michigan State Medical Society and the UAW-CIO

Members
R. L. Novy, M.D., *Chairman*
G. L. McClellan, M.D.
P. L. Ledwidge, M.D.
E. I. Carr, M.D.
S. W. Donaldson, MD.
Otto K. Engelke, M.D.

Alternates
R. H. Baker, M.D.
A. H. Kretchman, M.D.
L. O. Geib, M.D.
Wilfrid Haughey, M.D.
O. O. Beck, M.D.
A. S. Brunk, M.D.

ANNUAL REPORT OF COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION, 1943-44

The Michigan State Medical Society teaching program in postgraduate medical education for 1943-44 was given in the centers of Ann Arbor, Battle Creek-Kalamazoo, Bay City-Saginaw, Flint, Grand Rapids,

Lansing-Jackson, Mount Clemens, Traverse City, and in five centers in the Upper Peninsula: Sault Ste. Marie, Marquette, Houghton, Ironwood, and Powers. The Upper Peninsula program was given May 22 to 26, inclusive, in the above named centers in afternoon and evening sessions.

Attendance:

Ann Arbor	98
Battle Creek-Kalamazoo	129
Bay City-Saginaw	100
Flint	89
Grand Rapids	120
Lansing-Jackson	118
Mt. Clemens	40
Traverse City	65
Upper Peninsula (Sault Ste. Marie, Marquette, Houghton, Ironwood, and Powers)	125
	884

The following meetings have also been reported:

A postgraduate medical conference of the University of Michigan Medical School was held in Ann Arbor, on October 8, 1943, with 254 physicians registered. A program of the MSMS Industrial Health Committee in conjunction with the Department of Postgraduate Medicine of the University of Michigan was given in Detroit, on April 6, 1944, and was attended by 110 physicians. The Northern Tri-State Medical Association meeting held in Toledo, Ohio, on April 11, 1944, was attended by thirty-two Michigan physicians. On May 4, 1944, the annual Ingham County Clinic was held in Lansing, with 186 physicians in attendance. At the annual Alumni Conference of Wayne University College of Medicine, on May 10, 1944, there were 250 physicians in attendance of whom 220 were from Michigan.

Continuation Study Courses at Wayne University College of Medicine showed sixty-four registrations, and 344 registrations were reported from the Department of Postgraduate Medicine at the University of Michigan Medical School.

The MSMS granted seventy-seven certificates of Fellowship in Postgraduate Education and sixty-seven certificates of Associate Fellowship to Michigan physicians at the annual meeting in September, 1943.

At its November, 1943, meeting, your committee recommended that a historical review be made of Michigan State Medical Society activities since the publication of our Medical History. Among other items of interest, this publication would include the origin and progress of postgraduate medical education, the studies of the distribution of medical care and costs culminating in the present Michigan Medical Service Plan, and the results of several years of legislative studies which resulted in the present Michigan Basic Science Law. These constitute a record of accomplishment by the Society in which our members may take justifiable pride and their publication would give substantial evidence of our social as well as professional interests and activities.

At this committee's meeting in Detroit, on May 3, 1944, the following matters were discussed and actions taken:

1. The subject matter for the October program was discussed and decided upon. (Items reported in minutes of Committee Meeting, on May 3.)

2. The desirability of a more thorough understanding with the Michigan Department of Health than that which seems to have existed heretofore was discussed, and the chairman was instructed to issue a cordial invitation to the Commissioner of Health to attend the dinner meetings in our various centers during October and present his views on "The Relationship of Public Health and the Private Practice of Medicine."

3. In the past the programs for the Upper Peninsula have been assembled by the Postgraduate Committee on which two members of the Upper Peninsula hold membership. However, time and distance have prevented the attendance of our Upper Peninsula members at any of our meetings. As this seems likely to continue, your committee suggests a communication from the Council to the Upper Peninsula Medical Society, requesting that it appoint a small postgraduate committee to advise the central committee regarding time, place, and content of future Upper Peninsula programs for which the MSMS is responsible. It should be understood that the fulfillment of such suggestions will be subject to such changes by the central committee as the difficulties of these times present, particularly in relation to selection of personnel.

4. The committee believes that it is desirable that the councilor, so far as possible, preside at the postgraduate meetings in his area. There, however, many necessary local arrangements and details which quite frequently are impossible for him to care for. Failure to attend to these details not infrequently militates against the effective operation of a conference. This has been the subject of discussion from time to time within the committee and between the committee and local areas. Your committee suggests that a local physician, or physicians, preferably among the younger men, be appointed by the councilor to be accountable to him for the details of conferences. As a further suggestion your committee feels that on account of his knowledge of local professional affairs, a county society secretary might, wherever possible, serve effectively.

5. Your committee is concerned about the large number of general practitioners in the metropolitan area of Detroit not now receiving postgraduate work comparable to that afforded by the MSMS to other parts of the State. Your committee is in accord with the former program for Continuation Study developed by the Wayne County Medical Society and the Wayne University College of Medicine. At this time the committee reaffirms its recommendation of financial aid from the MSMS to the metropolitan area for that part of the educational program which provides for the general practitioner and expresses the hope for the earliest possible resumption of organized teaching in this area. Your committee further suggests that when and if this program be resumed that it be available to the practitioners of any part of the State of Michigan as a part of the educational program of the Michigan State Medical Society.

6. Postwar period. The Council, through Secretary Foster, requested suggestions designed to meet the educational needs of our members now in service upon their return to civil life.

(a) The committee believes that the framework of the present postgraduate program is adequate for the general practitioner and specialist in peacetime activities and should for the present, at least, be continued.

(b) The committee proposes the enlargement of the present educational programs within the hospitals of the State to permit their carrying on, with the coöperation of the medical schools, postgraduate instruction and direction for those who wish to qualify for the specialties after the war. This contemplates the assumption of personal guidance in the preparation of candidates for the various specialties by qualified staff members, a revival of the effective preceptorship function of former years. *The committee recommends that it be permitted to name a small committee to explore the educational possibilities in this field.*

(c) Eloise Hospital contains the greatest amount of teaching material in this part of the country and the committee wishes to bring together the facilities of both the Michigan medical schools to teach postgraduate and graduate medicine at Eloise. *It recommends a committee to study the possibilities suggested.*

On approval of the Executive Committee of The

Council of items "b" and "c" under "6," two committees were appointed to explore the educational possibilities in these two areas. They were instructed to proceed as rapidly as possible in order that their findings might be available to this committee for transmission to the Society at its Annual Meeting in September.

Respectfully submitted,

J. D. Bruce, M.D., *Chairman*
A. P. Biddle, M.D.
H. H. Cummings, M.D.
Chas. P. Drury, M.D.
W. B. Fillinger, M.D.
A. C. Furstenberg, M.D.
C. L. Hess, M.D.
Edgar H. Norris, M.D.
R. H. Pino, M.D.
J. M. Robb, M.D.
J. J. Walch, M.D.
F. F. Yonkman, M.D.

ANNUAL REPORT OF RADIO COMMITTEE, 1943-44

The radio program of the Michigan State Medical Society for the year 1943-1944 was made possible by the coöperation of Mr. Waldo Abbot, Director of the University of Michigan Broadcasting Service, and Dr. Charles A. Fisher, Director of the University of Michigan Extension Service. There was some delay in starting the program due to difficulty in obtaining a satisfactory radio hour. The program was finally inaugurated on April 27, 1944, with a weekly period over Station WJR. From April 27 through May, the broadcast was from 11:15 to 11:30 over Station WJR, but starting the first of June, the hour was changed from 11:30 to 11:45. The program was received enthusiastically and a great number of requests were received for reprints of the individual talks. The regular weekly broadcasts from April 27 through the month of July were as follows:

April 27—Dr. Richard H. Freyberg, Assistant Professor of Internal Medicine, University of Michigan Medical School, in Charge of the Rackham Arthritis Research Unit, University Hospital: Modern Treatment of Arthritis.

May 4—Dr. Ernest H. Watson, Instructor in Pediatrics and Communicable Diseases in the University of Michigan Medical School and Instructor in Child Health in the School of Public Health: Accidents in Childhood.

May 11—Dr. Robert A. Hettig, Instructor in Internal Medicine in the University of Michigan Medical School: Postwar Problems Relative to Tropical Diseases.

May 18—Dr. Russell N. DeJong, Associate Professor of Neurology in the University of Michigan Medical School: Sick Headaches: Their Significance and Treatment.

May 25—Dr. Richard H. Lyons, Assistant Professor of Internal Medicine in the University of Michigan Medical School: Swelling of the Ankles.

June 1—Dr. Paul H. Noth, Associate Professor of Medicine, Wayne University College of Medicine: You and Your Heart.

June 8—Dr. Henry Field, Jr., Professor of Internal Medicine, University of Michigan Medical School: Present Status of the Question of Vitamin Nutrition.

June 15—Dr. Leo H. Bartemeier, President of Michigan Society of Neurology and Psychiatry: Psychiatry and the War.

June 22—Dr. Frederick F. Yonkman, Professor of Pharmacology and Therapeutics, Wayne University College of Medicine: Those Drugs of Ours.

June 29—Dr. Clement A. Smith, Professor of Pediatrics in the Wayne University College of Medicine: The Prevention and Control of Tuberculosis in Childhood.

July 6—Dr. Robert C. Bassett, Instructor in Surgery in the University of Michigan Medical School: The Problem of Epilepsy.

July 13—Dr. Leonard E. Himler, Assistant Professor of Mental Health in the University of Michigan and Associate Psychiatrist in the University Health Service: Mental Hygiene Aspects of Industrial Rehabilitation.

July 20—Dr. H. Marvin Pollard, Assistant Professor of Internal Medicine in the University of Michigan Medical School: Gas.

July 27—Dr. Frank F. A. Rawling, Instructor in Internal Medicine in the University of Michigan Medical School: Allergy.

In addition to the regular programs listed above, there were two special programs sponsored in part by the Michigan State Medical Society. On March 3, 1944, over Station WKAR, East Lansing, a "Forum on Cancer" was held which was sponsored jointly by the Michigan State Medical Society and the Women's Field Army for the Control of Cancer. The medical members of the program were Sam W. Donaldson, M.D., Roentgenologist at St. Joseph's Mercy Hospital, Ann Arbor, and Henry J. Lange, M.D., Instructor in Surgery in the University of Michigan Medical School. A "Radio Medical Clinic" is also planned to be held as part of the program "In Our Opinion" which is sponsored jointly by Station WJR and the *Detroit Free Press*. This is given Sunday noon from 12:30 to 1:00. The participants in this program will be as follows: Paul S. Barker, M.S., Associate Professor of Internal Medicine in the University of Michigan Medical School: Cardiovascular Disease; Robert A. Hettig, M.D., Instructor in Internal Medicine in the University of Michigan Medical School: Tropical Diseases; Henry J. Lange, M.D., Instructor in Surgery in the University of Michigan Medical School: Cancer; and John B. Barnwell, M.D., Associate Professor of Internal Medicine and Director of the Tuberculosis Unit at the University Hospital: Tuberculosis.

The radio program for the present year has gone off fairly successfully in spite of the difficulty in inaugurating it. The coöperation of the University of Michigan has been very helpful and both Mr. Abbot and Dr. Fisher have rendered invaluable assistance. Through Dr. Fisher, reprints of the individual talks are available and a large number of requests for these have been received. There are certain difficulties associated with this program, however. One of these is that the University of Michigan must be listed as one of the sponsors of the program. Another difficulty is that the time must of necessity be on a donated hour and the hours during which the largest number of listeners are available are sold by the radio stations so that the donated hours must be at less popular times. It is the opinion of the members of the Radio Committee of the Michigan State Medical Society that the radio program of the Society would most effectively originate from the central office of the Society and should possibly be a part of either the Health Education Committee or the Public Relations Committee of the Society. The changing of the personnel of the Radio Committee each year makes it difficult to have a continuity of personnel and material and also brings about unnecessary delays in inaugurating the program each year. It would be very worth while for the House of Delegates of the Michigan State Medical Society to consider the obtaining of a permanent radio hour, possibly paid for through appropriations from the Society, so that a set time for the broadcasts could be had throughout the year. A permanent committee centering in the central office of the Society could have as part of its duty the arranging of this program on a perennial or perpetual basis. While it has been suggested that the radio broadcasts should be a part of either the Public Relations Committee or the Health Education Committee, it could also be considered a part of the Committee on Postgraduate Medical Education.

The opinion has been expressed by many people that broadcasts by individual doctors have a certain stigma associated with them and that they may be considered either advertising or publicity seeking moves, either for the individual himself or for the institution that he represents. The American Medical Association has available transcribed programs originating in the Bureau of Health Education of the Association (J.A.M.A., April 29, 1944, Volume 124, page 1273). Certain county and state societies have made use of these transcribed broadcasts for their medical radio programs (J.A.M.A., April 22, 1944, Volume 124, page 1204). It seems worth while to consider the use of these impersonal broadcasts either to supplement talks by members of the State Society or to take the place of talks by members

of the State Society. The talks are well planned and outlined and cover a variety of popular medical subjects. It seems that there would be certain advantages to broadcasting these transcribed programs in place of talks by individual members, although it must be stated that the members of the Michigan State Medical Society have been very co-operative in their consent to plan and give medical broadcasts.

Radio broadcasting certainly plays a function in public education and the Michigan State Medical Society is to be commended on fostering this type of health education.

Respectfully submitted,
RUSSELL N. DEJONG, M.D., *Chairman*
EVERT W. MEREDITH, M.D.
WM. HAMILTON, M.D.
J. H. MCMILLIN, M.D.
G. M. WALDIE, M.D.
FRANK WEISER, M.D.

ANNUAL REPORT OF COMMITTEE ON HEART AND DEGENERATIVE DISEASES, 1943-44

The Committee on Heart and Degenerative Diseases of the Michigan State Medical Society held no meetings in 1943-44, and therefore has no report to make.

Respectfully submitted,
HERMAN H. RIECKER, M.D., *Chairman*
B. I. JOHNSTONE, M.D.
JOHN LITTIG, M.D.
MARK MARSHALL, M.D.
WM. H. MARSHALL, M.D.
A. E. VOEGELIN, M.D.

ANNUAL REPORT OF TUBERCULOSIS CONTROL COMMITTEE, 1943-1944

1. The committee would like to encourage the survey work of the State Health Department.

2. The committee recognizes the increase in the number of cases of tuberculosis being found by voluntary, governmental and industrial agencies in routine x-ray surveys. The committee wishes to emphasize to the members of the MSMS that many of these cases appear healthy and free of symptoms and therefore are difficult of evaluation, and that such patients usually need the advice of a specialist in the field. In such cases, with or without admitted sputum, the committee recommends the examination by culture or guinea pig innoculation of the fasting gastric contents obtained before breakfast. This material can be sent to any one of the state laboratories for such an examination.

3. The committee applauds the present application of state subsidies in areas of high morbidity and low assessed valuation and believes that it has already improved tuberculosis control in the state.

4. It is hoped that further effort will be made toward making daily rates for the care of patients throughout the state more uniform. The difficulties in this problem, however, are recognized. It should be pointed out that the cost of controlling tuberculosis in any areas should be considered in terms of the total cost to the population of that area rather than a per diem cost per patient. The county boards of supervisors should then recognize that tuberculosis control cost means more than just hospitalization, and that where there exists a difference in hospital cost between two institutions they must give thought to the cost of out-patient and field service, and recognize this element in total cost of tuberculosis control in the area.

5. The committee would suggest that all sanatoria, either state or county, work out some arrangement for out-patient and field service with local health departments in the areas which these sanatoria serve.

6. The committee has noted some agreement and some discrepancies in the plans of the state official and voluntary agencies for a state program for the control of tuberculosis. The committee would like to see the agreement stressed and work progressed along those lines. It believes that such agreed policy can be presented to the state planning commission with benefit. In this connection, this committee of the MSMS wishes it recorded that it received no request for information or advice, and none has been offered.

7. The committee recognizes the state's purchase of the private sanatorium at Oshtemo, Michigan, for the care of active cases as a temporary expedient only, and recommends that it be continued only until proper facilities can be provided.

8. In answer to questions from members, this committee believes that members of the MSMS should, as good citizens, join and support the Michigan Tuberculosis Association in the same spirit that they support other voluntary organizations in the health field. The committee, however, disclaims any medical direction or advice to this lay organization.

Respectfully submitted,
JOHN BARNWELL, M.D., *Chairman*
CECIL CORLEY, M.D.
JOS. L. EGLE, M.D.
L. E. HOLLY, M.D.
W. L. HOWARD, M.D.
W. B. HOWES, M.D.
H. G. HUNTINGTON, M.D.
E. J. O'BRIEN, M.D.
GEO. A. SHERMAN, M.D.
JOHN TOWEY, M.D.

ANNUAL REPORT OF PUBLIC RELATIONS COMMITTEE, 1943-1944

This has been a very active year for this committee. As you know we have had follow-up work with the county societies and a great deal to do with lay organizations in the fight against socialized medicine and the Murray-Wagner-Dingell Bill.

All of the members of this committee have been very active in this work since the Secretaries Conference at Detroit on January 30, 1944.

A committee meeting was called at Lansing on February 20, 1944.

Extracts from the minutes of this meeting are as follows:

Public Relations Districts.—The chair announced that the state of Michigan had been divided into Public Relations Committee Districts, each district to be in charge of a member of the Public Relations Committee, as follows:

1. Dr. Pearse—District 1, Wayne County (west side).
2. Dr. Reed—District 2, 3, 4, Second: Eaton, Hillsdale, Ingham, Jackson; Third: Branch, Calhoun, St. Joseph; Fourth: Allegan, Berrien, Cass, Kalamazoo, Van Buren.
3. Dr. McCann—District 5, Barry, Ionia-Montcalm, Kent, Ottawa.
4. Dr. DeTar—District 6-14, Sixth: Clinton, Genesee, Shiawassee; Fourteenth: Lenawee, Livingston, Monroe, Washtenaw.
5. Dr. Herrington—District 7, Huron, Sanilac, Lapeer, St. Clair.
6. Dr. Clippert—District 8-10, Eighth: Gratiot-Isabella-Clare, Midland, Saginaw-Tuscola; Tenth: Alpena-Alcona-Presque Isle, Bay-Arenac-Gladwin-Iosco, Otsego-Montmorency-Crawford-Oscoda-Roscommon-Ogemaw.
7. Dr. Ramsdell—District 9-11, Ninth: Grand Traverse-Leelanau-Benzie, Manistee. Antrim-Charlevoix-Cheboygan-Emmet, Kalkaska-Missaukee-Wexford; Eleventh: Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana.
8. Dr. LaBine—District 12-13, Twelfth: Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger; Thirteenth: Dickinson-Iron, Gogebic, Houghton-Baraga-Keweenaw, Menominee, Ontonagon.

9. Dr. Henderson—District 15, Macomb, Oakland.
10. Dr. Candler—District 16, Wayne County (east side).

"Campaign against Medical Regimentation.—The committee discussed the need for such a campaign and the best methods to be employed. Dr. Clippert felt this matter should be explained to all service clubs, PTA, clergy, community leaders, nurses, and nurses aids throughout the state. Chairman Reed felt that the Wayne County Medical Society's booklet called "Facts and Comments," was excellent for use in preparing a talk against the Wagner-Murray-Dingell Bill.

"Use of Radio.—Motion of Drs. Candler-Clippert that this committee respectfully recommend to the council or its executive committee that monies be spent by the Public Relations Committee on the radio in a campaign against medical regimentation, utilizing the services of the regular advertising counsel. Motion carried unanimously.

"Use of Literature.—Motion of Drs. DeTar-Henderson that the chairman be authorized to request the council or its executive committee to obtain an ample supply of reprints of certain literature. Carried unanimously.

"Use of Lecturers.—Motion of Drs. McCann-DeTar that the society continue the practice of utilizing lay speakers on the present basis until such time as the Michigan Health Council or a similar organization is developed to carry on. Carried unanimously.

Discussion brought out that other groups, such as the Insurance Economics Society of America, which are fighting bureaucracy and regimentation, may have speakers' bureaus upon which the medical profession might call.

Motion of Drs. DeTar-Ramsdell that the Public Relations Committee request of the Council or its excutive committee permission to enlist speakers whose views are consistent with the philosophy of the medical profession on this subject, said speakers to be obtained at no expense to the State Society. Carried unanimously.

"Contacts with Newspaper Editors.—It was suggested that filler be sent out periodically to newspaper editors, either through the Michigan Press Association or directly from the State Society or from the Michigan Health Council when it began to function."

Following the meeting members of the committee have been active in addressing their county societies throughout the state and stimulating coöperation in this work. Practically all of the county societies have been contacted throughout the state and most of these meetings have been joint meetings with the Women's Auxiliaries. Pamphlets have been obtained and distributed at these meetings and throughout the county societies. These appear in the waiting rooms of most of the hospitals' and doctors' offices throughout the state. At all of these meetings Michigan Medical Service and Michigan Hospital Service have been stressed as the best means of combating federalization of medicine. The difference of cost under the Michigan plan and under the Murray-Wagner-Dingell Bill has been pointed out at all times. The un-American parts of the Murray-Wagner-Dingell Bill have been stressed at these meetings.

This work has been carried on very ably by members of the county medical societies who have addressed meetings of lay people wherever and whenever possible. Professor Floyd E. Armstrong has been utilized to address meetings of medical and lay groups at numerous places throughout the state. His talks have been well received and the comments of both medical and lay people have been observed. These have been uniformally satisfactory and I feel that Professor Armstrong has done a great deal in the establishment of closer cooperation and understanding in our state.

Time and space would not permit of a complete list of all the meetings and groups addressed by members of this committee. As an example your chairman has personally visited and addressed twelve county medical societies and auxiliaries as well as numerous lay groups during the past four months. Other members of the committee also have traveled far and addressed many groups and people in this work.

An Advisory Committee on radio has been appointed, composed of C. L. Candler, M.D., chairman, A. S. Brunk, M.D., President-elect of this Society and P. L. Ledwidge, M.D., Speaker of House of Delegates. This committee has formulated a radio program which began the last week of July, 1944, and carries through October 21, 1944. This program consists of twenty-six five-minute dramatic episodes dealing with "American Medicine." These will be broadcast over twelve stations of the Michigan radio network. There will also be a series of radio shorts beginning October 16, 1944, four per week for three weeks and five the final week. These will be broadcast over the same network as the dramatic episodes.

This work is continuing at this time with all members of the Public Relations Committee still addressing lay groups whenever the opportunity presents itself and will continue as long as our tenure of office. Your chairman feels that there is a great deal more to be done in this important work of your society. Further that the present Public Relations Committee has been a very active, energetic group and always coöperative. They have many times neglected their own professional needs to carry on in an unselfish manner this most important work. The chairman wishes to commend each individual member of my committee for the splendid service they have rendered to the MSMS during the past year.

Respectfully submitted,

Fred R. Reed, M.D., *Chairman*
C. L. Candler, M.D.
C. G. Clippert, M.D.
J. S. DeTar, M.D.
L. T. Henderson, M.D.
W. J. Herrington, M.D.
A. LaBine, M.D.
John J. McCann, M.D.
H. A. Pearse, M.D.
Homer Ramsdell, M.D.

ANNUAL REPORT OF THE PROCUREMENT AND ASSIGNMENT COMMITTEE 1943-1944

In October, 1943, the 9-9-9 program for interns, junior residents, and residents was inaugurated for approved hospitals to coincide with the shortened school year. The quota for each hospital was based on bed capacity and patient loads. In this way, the available interns and residents were distributed equally among the hospitals. A meeting was held with the hospitals to explain the program.

In order to correlate the industrial areas around Detroit, Macomb, Oakland, Monroe, and Washtenaw Counties, they were placed under the jurisdiction of Clarence D. Moll, M.D., vice chairman. All communications regarding these counties should be directed to the vice chairman.

The USPHS issued a directive and pamphlets offering $1000, or $350 for three months maintenance to any doctor relocating to a community needing medical care. The doctor must stay in the community for one year. The community must pay 25 per cent of this sum. Small villages are willing to pay, but enough doctors are not available for relocation. This plan is not feasible. There are only five small villages now needing help. Many relocations have been made during the year.

Doctors of Medicine are constantly desiring to enter hospitals for Postgraduate work, and leaving their locations without medical care. Also, many wish to practice in another state. This must be discouraged for the duration.

A resolution was referred to a committee to be presented to the House of Delegates of the MSMS regarding demobilization of medical men. Preference is to be given to those officers longest in service, older

officers to be demobilized first. The needs of the communities are also to be considered.

Questionnaires were sent to the doctors in an effort to have complete records. The coöperation of all the doctors is appreciated.

Respectfully submitted,
P. R. Urmston, M. D., *Chairman*
F. G. Buesser, M.D.
Warren B. Cooksey, M.D.
Milton A. Darling, M. D.
L. Fernald Foster, M.D.
L. A. Farnham, M.D.
C. D. Moll, M.D.
C. I. Owen, Lt. Col. MC.
H. H. Riecker, M.D.

REPORT OF THE VICE CHAIRMAN, COMMITTEE ON PROCUREMENT AND ASSIGNMENT, 1943-1944

Since the last report of the Committee on Procurement and Assignment Service the southeast five counties of the state, namely: Wayne, Monroe, Oakland, Washtenaw, and Macomb, have been placed under the jurisdiction of vice chairman for the State of Michigan. This because these five counties are in the so-called industrial district and have similar problems.

The recruiting program has been concerned largely with the commissioning of residents and interns and, under the 9-9-9 Program for Interns and Residents, has been working out rather satisfactorily. All physically eligible interns and residents are required to be commissioned before they can be deferred. Less emphasis is being placed on recruitment of doctors in private practice.

The medical care situation in the five counties above mentioned is relatively satisfactory, with the exception of an occasional isolated area in which a doctor has become incapacitated by illness or taken by death, thereby leaving the area without medical care. One such area at the present time is Manchester, where efforts are being made to relocate a doctor or return one from service who had previously practiced there.

Respectfully submitted,
Clarence D. Moll, M.D., *Vice Chairman*

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The fifty-fourth national convention of the Association of American Medical Colleges at Cleveland's Medical Center voted to hold next year's convention in Detroit, October 25-27, 1944. The decision was based on the Association's strong interest in the projected new $50,000,000 Medical Science Center of Wayne University, and its program, according to Dean Edgar H. Norris. This will be the first time the Association has ever met in Detroit, which may be taken as recognition that the Wayne College of Medicine ranks with the country's best institutions of its kind.

The Association numbers sixty-seven American medical colleges.

Infantile paralysis has been reported to be epidemic in North Carolina with over three hundred cases and in Kentucky with over one hundred cases so far this season. Through August 1, Detroit has had seventy cases and one death.

This number of cases is greater than were present this early in the season during the past two years. It is not in epidemic proportions.

Technical Exhibits

Abbott Laboratories — **Booth E-6**
North Chicago, Illinois

Abbott representatives J. J. McBrady and D. E. Ziegenbein will be in attendance and will welcome exchanging notes with you regarding the wide variety of Abbott products on exhibit here.
A number of new items have been added since last we attended the Michigan State Medical meeting so be sure to view this display.

A. S. Aloe Company — **Booth D-13**
St. Louis, Missouri

A. S. Aloe Company, Booth No. D-13, are showing a cross-section of their complete line of surgical and laboratory instruments and supplies. Featured will be American made stainless steel surgical instruments and such laboratory specialities as the Goth Kit for determination of sulfonamide concentration in blood and the new Somogyo Sugar Urine Comparator. Messrs. T. T. Boufford and H. J. Benedict, Aloe Michigan representatives, will be in charge of the booth.

The Baker Laboratories — **Booth B-2**
Cleveland, Ohio

Physicians are cordially invited to see a demonstration of a time-saving method for feeding infants in the hospital and at home. Baker's Modified Milk, a modern, highly nutritious food for infants will be featured in the display. Melcose, a completely prepared milk, and Melodex (maltose and dextrin) will also be exhibited. Our representatives will be in attendance to welcome you and explain the special advantages of Baker's infant foods.

Bard-Parker Company, Inc. — **Booth C-17**
Danbury, Connecticut

The following products will be exhibited at the Bard-Parker Booth No. C-17: Rib-Back Blades, Long Knife Handles for deep surgery, Renewable Edge Scissors, Formaldehyde Germicide and Instrument Containers, Transfer Forceps, Hematological Case for obtaining bedside blood samples.

Barry Allergy Laboratories, Inc. — **Booth C-7**
Detroit, Michigan

Carpule intradermal and speedy scratch testing equipment will be featured and technique regarding their use explained. The co-ordination of skin test reactions and a history toward the preparation of desensitization material will be displayed and explained by Mr. A. W. Barry.

W. A. Baum Company, Inc. — **Booth E-7**
New York, New York

The Lifetime KOMPAK and 300 MODEL Baumanometers cased in Duralumin as formerly and the STANDBY Model made of magnesium are again available. Increased production has resulted in the release of some of these critical metals for this use. All of these Models and a complete line of new replacement parts, will be on display in their Booth No. E-7.

Becton Dickinson & Company — **Booth C-3**
Rutherford, New Jersey

Featured in Becton, Dickinson's booth will be the Yale-Lok Syringe and the Yale Rustless Needle with new Huber point, specially designed to penetrate smoothly without cutting tissue plugs and with minimum laceration of tissue—less seepage, less pain.

Ernst Bischoff Company, Inc. — **Booth E-15**
Ivoryton, Connecticut

In our exhibit we shall feature Lobelin Bischoff, respiratory stimulant and resuscitant in asphyxia neonatorum; Anayodin, an effective, nontoxic amebacide; Diatussin and Diatussin Syrup, antispasmodic; Activin, a foreign protein for non-specific therapy; Viscysate, for the symptomatic relief of hypertension; Sas-Par, antipruritic, oral treatment for psoriasis.

The Borden Company **Booth C-8**
New York, New York



Visit Booth C-8 and learn about Borden's infant foods. Biolac in the new 13-ounce wartime tin . . . New Improved Dryco affording quicker solubility, lower cost, and increased vitamin potencies . . . Mull-Soy, the emulsified soy bean food for milk allergenic patients . . . Borden's Beta Lactose, nature's carbohydrate in an improved, readily soluble form . . . Also Klim and Merrell-Soule Powdered Milks.

Burroughs Wellcome & Co. (U.S.A.) Inc. **Booth C-22**
New York, New York



BURROUGHS WELLCOME & CO., New York, presents a representative group of fine chemicals and pharmaceutical preparations, together with new and important therapeutic agents of special interest to the medical profession.

Camel Cigarettes **Booths A-12, A-13**
New York, New York

CAMEL Cigarettes will exhibit large detailed photographs of equipment used in comparative tests of the five largest-selling brands of cigarettes. Representatives will be available to discuss research. Trans-Lux News will be supplied throughout the meeting.

Cameron Heartometer Company **Booth B-7**
Chicago, Illinois

THE CAMERON HEARTOMETER COMPANY is showing the improved Heartometer, a scientific precision instrument for accurately recording systolic and diastolic blood pressures. It also furnishes a permanent graphic record of the pulse rate, the nervous functioning of the heart, the myocardial response, as well as the functioning of the values. The Heartometer clearly reveals heart disturbances in both early and advanced stages and is of great value in checking the progress of medication and treatments.

Cameron Surgical Specialty Company **Booth C-5**
Chicago, Illinois

See the Cameron Flexible Gastroscopes and Cavicamera, the new Cameron Coagulo-Sigmoidoscope, Electro-Diagnostosets, Bronchoscopes-Esophagoscopes-Laryngoscopes, Binocular Prism Loupe, Mirrolite Magniscope and other new developments in electrically lighted Diagnostic and Operating Instruments. Cameron Electro-Surgical Units will also be on display.

Carnation Company **Booth E-9**
Milwaukee, Wisconsin



You are invited to visit the Carnation Company booth, No. E-9, where you will find presented some interesting information on the various uses of Irradiated Carnation Milk for infant feeding, child feeding and general diet purposes. Valuable literature will also be available for distribution.

Ciba Pharmaceutical Products, Inc. **Booth A-4**
Summit, New Jersey

Ciba invites you to visit its display at Booth No. A-4. Among the products displayed will be PRIVINE, as nasal vasconstrictor; METANDREN LINGUETS, a potent androgen for oral use; NUPERCAINE, a spinal anesthetic; VIOFORM, a non-irrating antiseptic and many others. Drop in and discuss these products with our representatives who will be ready to answer any question you may have.

The Coca-Cola Company **Booth A-11**
Atlanta, Georgia

Coca-Cola will be served to members with the compliments of the Coca-Cola Company.

Cream of Wheat Corporation **Booth E-5**
Minneapolis, Minnesota



In booth No. E-5, both "Enriched 5-Minute" and "Regular" CREAM OF WHEAT will be on display. "ZING!," stabilized Wheat Germ, will also be available for inspection. It is an economical, high vitamin germ that has been specially stabilized to prevent rancidity.

Davis & Geck, Inc. **Booth A-8 & Cinema Room**
Brooklyn, N. Y.

DePuy Manufacturing Company **Booth E-14**
Warsaw, Indiana

Fracture Appliances and the Lambotte Fixateur—external fixation appliance for compound fractures of the long bones, will be explained by our representative, Mr. Chas. F. Klingel.

Detroit Creamery Company **Booth D-15**
Detroit, Michigan



The Sealtest display represents the milk and ice cream plants in Michigan affiliated with Sealtest, Inc., and National Dairy Products Corporation. Mr. Leonard, of the Arctic Ice Cream plant, Grand Rapids, and Mr. Fudge, of the Grand Rapids Creamery, will be in charge of the exhibit.

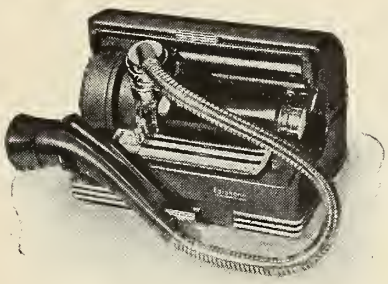
Doho Chemical Corporation **Booth D-7**
New York, New York

The Auralgan Exhibit consists of a model of the human auricle four feet high together with a series of twenty-four three-dimensional ear drums, modeled under the supervision of outstanding otologists. Each of these drums depicts a different pathologic condition based upon actual case observation and prepared, in so far as possible, with strict scientific accuracy so as to be highly instructive and interesting to all physicians.

Duke Laboratories, Inc. **Booth A-10**
Stamford, Connecticut

At Booth A-10, Duke Laboratories, Inc., will have on display their stretchable, cotton-woven, adhesive-surface bandages and compresses, Elastoplast and Mediplast, used by practically every large defense plant in the country. There will also be on display Aquaphor, Nivea Creme, Nivea Skin Oil, Basis Soap and Tecto.

The Ediphone Company **Booth D-19**
Grand Rapids, Michigan



The Ediphone Company extends a cordial invitation to all physicians to visit the display of Ediphone equipment. See the new Edison Electronic Voicewriter, also Miracle Model Voicewriter, manufactured by Edison, who invented and perfected sound recording. Stop in for demonstration and to learn how we are helping the Medical Profession in this crisis.

Ethicon Suture Laboratories **Booth E-18**
New Brunswick, New Jersey

Tantalum wire sutures will be shown to physicians and surgeons visiting the Ethicon Suture Laboratories Exhibit.
Visitors at Booth E-18 will also be shown recent advances in nylon, cotton, gastro-intestinal, eye and cosmetic sutures.
Mr. M. C. Thompson will be in charge of the Booth.

C. B. Fleet Company, Inc. **Booth E-8**
Lynchburg, Virginia

This exhibit will feature Phospho-Soda (Fleet), which has been an ethical product for over half a century. This is a pure, stable, aqueous concentrate of the two U. S. P. sodium phosphates. It is indicated in hepatic and gallbladder dysfunctions and whenever a thorough eliminating action is desired. It possesses rapidity and mildness of action, with marked absence of nausea, griping or tenesmus.

General Electric X-Ray Corporation **Booth A-7**
Detroit-Lansing-Grand Rapids

We cordially invite the physicians and their families who attend this Annual Session to make use of the lounge facilities provided at our booth for their comfort. We particularly look forward to a visit from users of our equipment, and a cordial invitation is extended to all physicians who may have technical problems to discuss with our staff in attendance.

Gerber Products Company **Booth B-9**
Fremont, Michigan



Gerber's CEREAL FOOD and STRAINED OATMEAL are enriched and precooked. We invite your inspection of the literature and the display of the Gerber Foods.

Hanovia Chemical and Manufacturing Company
Newark, New Jersey **Booth D-9**

Hanovia Chemical and Manufacturing Company will exhibit a complete line of high-pressure self-lighting ultraviolet lamps for orificial and general body irradiation. A feature of the display will be the Hanovia Safe-T-Aire lamps for the destruction of air-borne bacteria. Our representatives will welcome your questions and interest in our product.

J. F. Hartz Company **Booths D-12, D-14**
Detroit, Michigan

The J. F. Hartz Company is looking forward to again meeting its friends at the 1944 Michigan State Medical Postgraduate Conference.
Our exhibit there will feature Hartz Laboratory controlled Pharmaceuticals as well as Physician and Hospital equipment and instruments.

H. J. Heinz Company **Booth D-20**
Pittsburgh, Pa.

Hoffman-La Roche, Inc. **Booth E-17**
Nutley, New Jersey

Pharmaceutical prescription specialities of rare quality, produced at Roche Park, where Vitamins are made by the ton, will be exhibited.
Syntropan, the antispasmodic that is replacing Belladonna, will be a featured product. The medical profession's interest in the many uses of the versatile Prostigmin and other scientific accomplishments will be satisfied by Hoffman-La Roche representatives who will be in attendance to discuss clinical problems.

Holland-Rantos, Inc. **Booth B-15**
New York, New York

A complete unit for contraceptive technique. Provides for patient comparison of Jelly and Cream. Contains, in a handsome case: Koromex diaphragm with special pouch; Koromex Trip Release Introducer (takes all sizes diaphragms); Tube Koromex Jelly (higher lubricating factor); Tube Koromex Cream (lower lubricating factor); Set Dickinson-Freret Fitting Charts.

G. A. Ingram Company **Booths C-2, C-4, C-6**
Detroit, Michigan

The G. A. Ingram Company of Detroit will exhibit a complete line of surgical instruments in both stainless steel and chrome, as well as all available electrical appliances. Their representatives will be more than pleased to have you call and obtain information on both new and old items.

"The 'Junket' Folks" **Booth B-13**
Little Falls, New York

In space B-13, "The 'Junket' Folks," Chr. Hansen's Laboratory, Inc. Enlarged photos illustrate the action of the rennet enzyme in forming softer finer milk curds. Free literature describes dietary uses of rennet-custards in infant, child, convalescent, or post-operative feeding. Home Economists, Faithe Williams and Thelia Bock on duty. Complimentary package of "Junket" Rennet Powder and "Junket" Rennet Tablets presented to physicians who register.

Kellogg Company **Booth E-10**
Battle Creek, Michigan



All Kellogg's ready-to-eat cereals contain valuable whole-grain nutrients. Corn Flakes and Rice Krispies, low fiber cereals, are indicated in wheat-free and low residue diets. All-Bran, containing only 8% actual fiber, contributes Vitamin B_1, iron, and niacin to the diet.
Kellogg's Pep whole wheat flakes is fortified with additional vitamins B_1 and D.

A. Kuhlman & Company **Booth D-8**
Detroit, Michigan

Lea & Febiger **Booth C-10**
Philadelphia, Pennsylvania

At Booth C-10 Lea & Febiger will exhibit among their new works, Babcock's "Principles and Practice of Surgery," Donaldson's "Surgical Disorders of the Chest," Lewin on Bachache and Sciatica and new editions of Spaeth's "Ophthalmic Surgery," Rowe's "Elimination Diets and the Patient's Allergies," Simmons and Gentzkow's "Laboratory Methods of the United States Army," Bell's "Textbook of Pathology," Rhinehart's "Roentgenographic Technique," Craig and Faust's "Clinical Parasitology," Kraines' "Therapy of the Neuroses and Psychoses," Ballenger on the Nose, Throat and Ear, Ballenger's Manual, Boyd's "Textbook of Pathology," Ormsby and Montgomery on Diseases of the Skin, Levinson and MacFate's "Clinical Laboratory Diagnosis" and Gray's Anatomy.

Lederle Laboratories, Inc. **Booth E-1**
New York, New York

At the Lederle Laboratories, Inc., exhibit, Michigan representatives of the organization will welcome their many Michigan medical friends. They will show their general biological and pharmaceutical line with special emphasis on Penicillin and Sulfonamide products.

Libby, McNeill & Libby **Booth D-22**
Chicago, Illinois

Libby's Strained and Homogenized Baby Foods are featured at the Libby booth. Physicians are invited to stop and discuss new findings on the greater availability of iron and ease of digestion of Libby's Council-accepted foods for babies.

Eli Lilly & Company **Booth A-1**
Indianapolis, Indiana

J. B. Lippincott Company **Booth A-6**
Philadelphia, Pennsylvania

Showing the complete list of LIPPINCOTT SELECTED PROFESSIONAL BOOKS, with many new titles and new editions of old favorites, and the ever-new LIPPINCOTT JOURNALS. New items of special interest include—Bunnell: SURGERY OF THE HAND; Simmons-Wayne: GLOBAL EPIDEMIOLOGY; the American Edition of Fry: THE DENTAL TREATMENT OF MAXILLO-FACIAL INJURIES; Brown-McDowell: SKIN GRAFTING OF BURNS; Heuer: TREATMENT OF PEPTIC ULCER; Barach: PRINCIPLES AND PRACTICE OF INHALATIONAL THERAPY; Hotchkiss: FERTILITY IN MEN, and Siegler: FERTILITY IN WOMEN, and the new Twelfth Edition of LIPPINCOTT'S QUICK REFERENCE BOOK OF MEDICINE AND SURGERY.

The Liquid Carbonic Corporation **Booth D-5**
Wall Chemicals Division
Detroit, Michigan

The Medical Gas Division of the Liquid Carbonic Corporation will feature in their exhibit the following medical gases in various size cylinders: nitrous-oxide, medical oxygen, ethylene, cyclopropane, car-

bon-dioxide, carbon dioxide-oxygen mixtures, etc., together with equipment for administering the same. Our representatives in attendance will be Mr. J. J. Esop and Mr. E. G. Madole.

M & R Dietetic Laboratories, Inc. **Booth C-19**
Columbus, Ohio

M & R Dietetic Laboratories, booth No. C-19, will display Similac, a food for infants deprived either partially or entirely of breast milk; also powdered SofKurd. H. Behncke and L. A. MacDonald will appreciate the opportunity to discuss the merit and suggested application of these products.

McKesson Appliance Company **Booth E-16**
Toledo, Ohio

McNeil Laboratories, Inc. **Booth E-20**
Philadelphia, Pa.

Mead Johnson & Company **Booths B-10, B-12**
Evansville, Indiana

Medical Arts Surgical Supply Company **Booths**
Grand Rapids, Michigan **C-9, C-11, C-12, C-14**

The Medical Arts Surgical Supply Company of Grand Rapids will show in their exhibit the latest in medical furniture, short wave equipment, surgical pumps and surgical instruments. Those in attendance will be S. L. Lepard, M. J. Allen, R. V. Oosting, Ed Williams, George Klaver, and Harold Hadden.
In addition to this they will occupy a space showing their latest in laboratory items.

Medical Case History Bureau **Booth A-14**
New York, New York

Representatives will demonstrate **patient's history record charts** for general practice and all specialties; also **simple and efficient bookkeeping cards.** Of special interest is the unique method by which interesting cases may be cross-indexed according to the disease, directly on the patient's history chart.
A few minutes spent in this booth may prove to be a great time saver in your office record system.

Medical Film Guild **Booth A-16 and Cinema Room**
New York, New York

Medical Film Guild emphasizes its talking papers in this year's program of "MEDICAL FILMS THAT TEACH." Hospital and Medical Society program chairmen, now faced with depleted staffs because of the war emergency, who desire educational material for their meetings, find that Medical Film Guild's motion picture film text books answer that important problem. Through grants for post graduate instruction, these films are available at no charge to any hospital or medical society meeting and to the medical services connected with the Armed Forces of the United States. Exhibition is also included at no charge under this plan. Subjects available are: INGUINAL HERNIOPLASTY, ASPHYXIA NEONATORUM, NONOPERATIVE TREATMENT OF PARANASAL SINUSITIS, OTITIS MEDIA IN PEDIATRICS, A CLINIC ON ACUTE MASTOIDITIS, OTOSCOPY IN THE INFLAMMATIONS, A CLINIC ON SIGMOID SINUS THROMBOSIS, A CLINIC ON PETROSITIS WITH MENINGITIS, PHARMACOLOGY OF RESPIRATORY STIMULANTS, AMEBIASIS AND ITS TREATMENT, A CLINIC ON OTITIC PURULENCIES.

Medical Protective Company **Booth C-20**
Fort Wayne, Indiana

The most exacting requirements of adequate liability protection are those of the professional liability field. The Medical Protective Company, speciaists in providing protection for professional men, invites you to confer, at their exhibit, with the representative there. He is thoroughly trained in Professional Liability underwriting.

Mellin's Food Company **Booth E-13**
Boston, Massachusetts

The Annual Session of the Michigan State Medical Society affords an opportunity for the exchange of ideas and opinions relative to the feeding of infants and in regard to the preparation of nourishment for adults requiring restricted diet. Representatives of the Mellin's Food Company will be pleased to discuss the subject.

Merck & Co., Inc. **Booth B-17**
Rahway, New Jersey

Physicians attending the 79th Annual Session of the Michigan State Medical Society are cordially invited to visit the Merck booth. Literature will be available on Merck Medicinal Specialties and also on penicillin, the vitamins, and the sulfonamides. If you are interested in an inhalation anesthetic for short operative procedures, ask about Vinethene. It produces rapid induction of anesthesia and rapid, complete recovery with infrequent nausea or vomiting.

The Wm. S. Merrell Company **Booth E-2**
Cincinnati, Ohio

Members and guests are invited to stop for a copy of the interesting and instructive booklet, "Can Oral Vaccines Protect Against the Common Cold?" presenting a review of published reports on both sides of this timely question. Well-known Merrell prescription specialties will also be on display at the booth.

Michigan Medical Service **Booth E-22**
Detroit, Michigan

C. V. Mosby Company **Booth B-11**
St. Louis, Missouri

New books and new editions to be displayed by the C. V. Mosby Company will include Dodson "Urological Surgery," Meakins "Practice of Medicine," Selling "Synopsis of Neuropsychiatry," Kuhn "Industrial Ophthalmology," Herrmann "Synopsis of Diseases of the Heart and Arteries." Titus "Management of Obstetric Difficulties," and Davison "Synopsis of Materia Medica, Toxicology and Pharmacology." Mr. Arthur Garbruck will be in attendance and glad to discuss your book needs with you.

National Live Stock and Meat Board **Booth E-19**
Chicago, Illinois

A charming, illustrated nutrition book for children, entitled **You and Your Engine,** has just been published by the National Live Stock and Meat Board and is ready for distribution. This book, plus a new set of charts in full color, the Nutrition Yardstick and other educational literature, will be displayed in Booth No. E-19.

Ortho Products, Inc. **Booth D-11**
Linden, New Jersey

Ortho's exhibit will feature their council-approved products for the control of conception. Booklets, reprints, etc., will be distributed, dealing with various methods. Ask for the recently published, "Studies in Human Fertility," a scientific digest dealing with the many aspects of fertility control.

Parke, Davis & Company **Booths D-1, D-3**
Detroit, Michigan

You will find displayed at the PARKE-DAVIS BOOTH many outstanding Pharmaceuticals and Biologicals. Included in this Technical Exhibit are such noteworthy products as PHEMEROL, a new type of germicide and antiseptic; ADRENALIN PREPARATIONS; MAPHARSEN; THEELIN; DESPECIATED ANTITOXINS; also other therapeutic agents of current interest. You are cordially invited to visit this Exhibit.

Pelton & Crane Company **Booth D-17**
Detroit, Michigan

Pet Milk Company **Booths C-16, C-18**
St. Louis, Missouri

A complete display of material illustrating the time-saving Pet Milk services available to physicians. Specially trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit.

Philip Morris & Co. Ltd., Inc. **Booth B-8**
New York, New York



Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

Pitman-Moore Company **Booth E-12**
Indianapolis, Indiana

Procter & Gamble Company **Booth C-13**
Cincinnati, Ohio



The makers of Ivory Soap, Procter & Gamble, will occupy Booth C-13. You are invited to stop at the exhibit and receive a free sample of Ivory Soap, a copy of the booklet "The Story of Soap," and a reprint of an article "Tests for Mildness of Soap."
Also, Procter & Gamble will be glad to supply you with a quantity of the booklet "Bathing Your Baby —The Right Way," which is proving to be a time-saver for doctors and nurses, and a real help to new mothers.

Professional Management **Booth D-6**
Battle Creek, Michigan

"A Complete Business Service For The Medical Profession." Eleven years of service to Michigan Doctors featuring **business counsel, tax advice** and planning of **record systems.**

Radium Emanation Corporation **Booth E-3**
New York, New York

The Radium Emanation Corporation (Booth E-3) will display Removable and Permanent Radon Seeds, implanters and other up-to-the-minute Radon and Radium applicators for Cancer-therapy. The new Ametal Rubber Inverted T-tube and improved Pessary (Regaud technique in Cervix Carcinoma), and the new naso-phasyngeal applicators will be demonstrated.

Randolph Surgical Supply Company **Booth A-9**
Detroit, Michigan

Randolph Surgical will again display unusual and distinctive equipment, as manufactured by the countries' leading manufacturers—our representatives who will be happy to serve you will be—Ted Ward, J. J. Mueller, and Cliff Randolph.

Riedel-de Haen, Inc. **Booth E-11**
New York, New York

The Riedel-de Haen, Inc., exhibit at booth No. E-11 will display Decholin, a hydrocholeretic, Degalol, a choleretic, and Cholmodin, a laxative agent. Physicians are cordially invited to discuss with our representatives the wide therapeutic applications of these chemically pure bile acid products.

W. B. Saunders Company **Booth A-2**
Philadelphia, Pennsylvania

This publishing house will exhibit their complete line of books. Included among the new and important books to be shown are: Bockus' 3-volume work on "Gastro-enterology," 5th edition of Christopher's "Minor Surgery," Erich & Austin's "Traumatic Injuries of Facial Bones," Hoffman's "Female Endocrinology," Moll's "Aesculapius in Latin America," Orr's 1-volume "Operations in General Surgery," Pullen's "Medical Diagnosis," the (20th) edition of the illustrated Medical Dictionary, new (3rd) edition of Stokes' "Syphilology," 1944 Mayo Clinic Volume, Lundy's "Anesthesia," Wharton's "Gynecology and Female Urology," the Military Medical and Surgical Manuals, Official U. S. Public Health Service Industrial Hygiene Manual, Stieglitz' "Geriatrics," Weiss & English's "Psychosomatic Medicine," and many others.

Schenley Research Institute **Booth D-10**
New York, New York

Schering Corporation **Booth E-21**
Bloomfield, New Jersey

Schering Corporation, in line with their policy of bringing out the latest in endocrine research, is featuring the new estrogenic product—ESTINYL Tablets.
ESTINYL, a derivative of the natural hormone alpha-estradiol, is most economical and is orally effective in dosage of .02 and .05 mg. It produces very little nausea and toxic side effects. Other Schering preparations on display will be ORETON-F Pellets, ORETON, ORETON-M Tablets, PROGYNON-B, PRANONE, PROLUTON, and CORTATE, and the diagnostic products for X-ray—NEO-IOPAX and PRIODAX.

Scientific Sugars Company **Booth C-1**
Columbus, Indiana

G. D. Searle & Company **Booth A-3**
Chicago, Illinois



G. D. Searle & Co. will show a number of the new products of Searle Research which has contributed so much to the recent armamentarium of the physician. Products such as Searle Aminophyllin, Metamucil, Ketochol, Furmerane, Floraquin, Gonadophysin, Tetrathione, and Pavatrine are results of this research which has been greatly expanded in the new Searle Research Laboratories.
An illustration of the new Laboratories will be features in the exhibit.

Sharp & Dohme, Inc. **Booth D-21**
Philadelphia, Pennsylvania

Sharp & Dohme will have their display at Booth No. D-21 featuring their new sulfonamide, Sulfamerazine, and also "Sulfasuxidine," "Lyovac" Normal Human Plasma, Tyrothricin Concentrate for human use, "Depropanex," "Delvinal" Sodium, "Propadrine" Hydrochloride products and "Lyovac" Tetanus Antitoxin, Bovine. Our representatives, Messrs. R. L. Moser, A. C. Edmunds and R. K. Fiddes, will be on hand to welcome all visitors and furnish information on Sharp & Dohme products.

Singer Sewing Machine Company **Booths D-2, D-4**
New York, New York

Smith, Kline & French Laboratories **Booth E-4**
Philadelphia, Pennsylvania

Benzedrine Sulfate Tablets and Pragmatar are featured at this exhibit.
The potent central nervous stimulation of benzedrine sulfate offers, throughout a wide range of application, "a therapeutic rationale which, in its very efficiency, cuts across the old categories."
Pragmatar—a significant improvement in tar-sulfur-salicylic acid ointments—is highly effective in an unusually wide range of common skin disorders, including subacute and chronic eczemas; subacute and chronic fungous infections; psoriasis; seborrheic affections; pityriasis rosea; etc.
Our especially trained professional representatives will be glad to discuss with you the potentialities and possible indications of our products in your own practice.

Spencer Incorporated **Booth C-15**
New Haven, Connecticut

You are cordially invited to visit our exhibit, featuring individually designed support for abdomen, back and breasts. Doctors will be especially interested in the scientific service for patients who have undergone mastectomy, and in the spinal support as an aid to treatment of ruptured disc and other back derangements. Supports for hernia, visceroptosis with symptoms, postoperative, obesity, maternity and post-partem are also on display.

E. R. Squibb & Sons **Booth B-4**
New York, New York

Physicians attending the Michigan State Medical Society meeting are cordially invited to visit the Squibb Exhibit, Booth No. B-4. Several new items will be shown. Among them is intocostrin, the standardized Purified Curare Extract now widely used to soften convulsion in shock therapy; a new, highly useful therapeutic multi-vitamin preparation; a sulfathiazole-ephedrine-derivative combination for ophthalmic use. Information on new products useful in venereal disease therapy and control will also be available.

Frederick Stearns & Company **Booths B-3, B-5**
Detroit, Michigan

Doctors are cordially invited to visit our attractive convention booth to view and discuss outstanding contributions to medical science developed in the Scientific Laboratories of Frederick Stearns & Company.

Our professional representatives will be pleased to supply all possible information on the use of such outstanding products as Neo-Synephrine Hydrochloride for intranasal and ophthalmologic use, Neo-Synephrine Sulfathiazolate, Amino Acids (Parenamine) for parenteral and protein feeding, Mucilose for bulk and lubrication, Fergon (Ferrous Gluconate), Gastric Mucin, Susto, Trimax, Appella Apple Powder, Nebulator with Nebulin A, and our complete line of Vitamin products.

William R. Warner & Co., Inc. **Booths D-16, D-18**
New York, New York

William R. Warner & Co., Inc., will exhibit its extensive line of specialty pharmaceuticals, including several new preparations of interest to physicians engaged in general and specialized practice.

Westinghouse X-Ray Company **Booth A-15**
Detroit, Michigan

White Laboratories **Booth B-6**
Newark, New Jersey

Winthrop Chemical Co., Inc. **Booth B-1**
New York, New York

Wyeth Incorporated **Booths B-14, B-16, B-18, B-20**
Philadelphia, Pennsylvania
Bovinine Company **Petrogalar Laboratories**
Reichel Laboratories **S. M. A. Corporation**
John Wyeth & Brother

The Wyeth display will graphically illustrate allergy and peptic ulcer diagnosis, treatment of constipation, and a new method of evaluating the physical fitness of the adolescent.

Pharmaceutical, biological, and nutritional representatives will be in attendance.

Zimmer Manufacturing Company **BoothA-5**
Warsaw, Indiana

The Zimmer Manufacturing Company will exhibit a full line of splints and bone instruments. The Corbett Finger and Thumb Splints, and also the new Stryker Screw Driver will be featured among the new items on display. Complete demonstrations of the Zimmer Reduction-Retention Apparatus will be given upon request, and pictures showing the results of its use will be on display.

Be Sure to Visit
Every Booth
There is much that is new and interesting.

To our business friends in the Technical Exhibit, the Michigan State Medical Society expresses sincere thanks for their splendid cooperation and very tangible contribution to the great success of the 1944 Conference.

FOR THE *Rest*
OF YOUR LIFE!



After a day's work well done, rest takes on added lift and comfort . . . when a man surrounds himself with the right sports clothes. Whaling Sportswear is the product of Clothing hands and a menswear viewpoint . . . seen and felt in the extra ease and casual smartness that only well-chosen apparel can contribute. To list a few:

Sports Jackets . . . . . 22.50 to 39.50
Sports Slacks . . . . . 7.50 to 25.00
Sports Shirts . . . . . 4.50 to 10.50
Leisure Coats priced from 15.00

WHALING'S
MEN'S WEAR • 617 WOODWARD
Detroit 26, Michigan
Monday Store Hours: Noon to Nine

YOU AND YOUR BUSINESS

DETROIT INSTITUTE OF CANCER RESEARCH

The Detroit Institute of Cancer Research has purchased, from the Detroit Edison Company, the Detroit Edison Club property at the northeast corner of St. Antoine and Frederick, will remodel the two buildings there as a temporary cancer research laboratory, and plan to make the grounds available as a playground for children of the neighborhood.

Rollin H. Stevens, M.D., President of the Institute, made this announcement. The property is 200 feet by 150 feet. The Institute has already requested the Department of Parks and Recreation to provide playground supervision, and, if supervision is granted, the major part of the grounds, formerly used as tennis courts, will be opened to the public.

"We chose this location because it is on the site of the projected Medical Science Center," Dr. Stevens said. "We expect to work very closely with the Wayne University College of Medicine, which will be the nucleus of the Center, and so our situation in this particular place will be of great advantage to both the Institute and the Center. Eventually we expect to replace the present buildings with a large new laboratory, fully equipped and staffed.

"Establishment of the new cancer research laboratories is the first step in making Detroit an important center of the battle against cancer.

"Detroit needs a fully developed cancer research program as badly as it needs its Medical Science Center. It is the only city of its size without such a program. Acquisition of the new site and the development of a close working relationship with the Medical Science Center and other institutions, will mean that, for the first time in its history, Detroit has joined other major cities in the campaign against cancer."

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The annual meeting of the American Board of Obstetrics and Gynecology was held at Pittsburgh, Pennsylvania from June 7 to June 13, 1944, at which time ninety-three candidates were certified.

A number of changes in Board regulations and requirements were put into effect, designed to aid both civilian as well as candidates in the Service. Among these is the waiver, temporarily, of our AMA requirement for men in the Army or Navy, especially for those who proceeded directly or almost so from hospital services into Army or Navy Service, upon a statement of intention to join promptly upon return to civilian practice. At this meeting the Board also has accepted a period of nine months as an academic year in satisfying our requirement for certain years of training. This is only for the duration and even men who are not eligible for military service but who are, nevertheless, in hospitals where the accelerated program is in effect have been allowed to submit to us this short-time period of training in lieu of our previous requirements.

Beginning with the next written examination, which is scheduled to be held the first Saturday afternoon in February, 1945, this Board will limit the written examination to a maximum period of three hours and, in submitting case records at this time, all candidates' case abstracts, whose obstetrical reports do not include measurements either by calipers and, as indicated, by acceptable x-ray pelvimetry, will be considered incomplete.

PROFESSIONAL PROTECTION

SINCE 1899 SPECIALIZED SERVICE

In addition to our Professional Liability Policy for private practice we issue a special
MILITARY POLICY
to the profession in the Armed Forces at a
REDUCED PREMIUM

THE
MEDICAL PROTECTIVE COMPANY
OF
FORT WAYNE, INDIANA



From the name Zemmer

You may know that for 42 years a complete line of ethical pharmaceuticals have been offered to the medical profession.

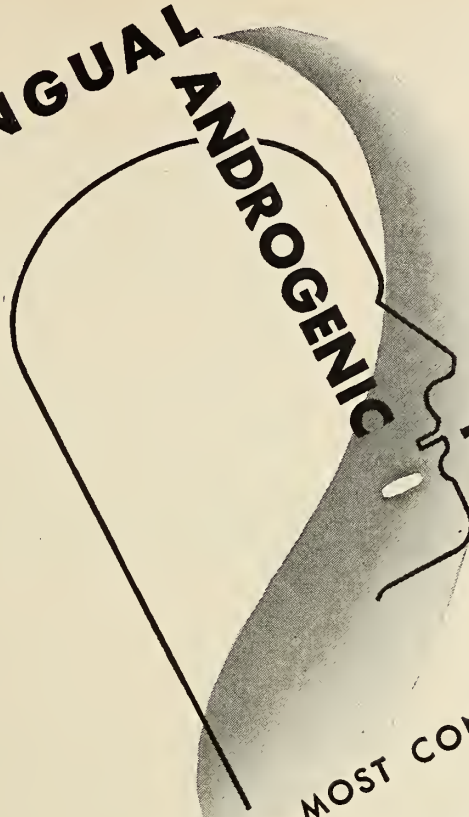
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Chemists to the Medical Profession

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MOST ECONOMICAL • MOST CONVENIENT

METANDREN LINGUETS*

(METHYLTESTOSTERONE)

Small, hard pressed wafers, especially designed for systemic absorption via the oral mucous membranes, thus side-tracking the liver where partial inactivation of ingested methyltestosterone is known to take place.[1]

Effective in smaller doses, e.g. 1/2 to 2/3 the amount required when methyltestosterone is swallowed.[2]

Cost of treatment with METANDREN LINGUETS is considerably less than when androgens are administered by injection, implantation or ingestion.

[1] Biskind, G. R.: Proc. Soc. Exper. Biol. & Med. 43:259, 1940. Burrill, M. W. and Greene, R. R.: Endo. 31:73, 1942.

[2] Lisser, H. and Curtis, L. E.: J. Clin. Endo. 3:389, 1943. *Trade Mark Reg. U. S. Pat. Off.

a Ciba Product

CIBA PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY

MICHIGAN'S DEPARTMENT OF HEALTH

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

INCREASE OF VENEREAL DISEASE

A 53 per cent increase in gonorrhea for the first five months of the year is reported by the Bureau of Venereal Disease Control. From January 1 through May 31 there were 4,785 new cases of gonorrhea reported against 3,111 reported during the same period last year.

Reported cases of syphilis increased 26 per cent through May with a total of 7,129 cases against 5,669 last year.

The Michigan increase coincides with a nation-wide trend. The U. S. Public Health Service places part of the blame for the increase in gonorrhea among civilians upon self-treatment with sulfa drugs.

FEVER TREATMENT FOR NEURO-PSYCHIATRIC CHILDREN

Children with neurosyphilis who are in need of fever therapy will be accepted by the State Hospital Commission on the same basis that adults have been accepted in the past. Patients are admitted on a voluntary basis to any of the following mental institutions for administration of this treatment: Kalamazoo State Hospital, Pontiac State Hospital, Traverse City State Hospital, Newberry State Hospital, or Ypsilanti State Hospital. Written application must be made to the medical superintendent of the hospital.

EMIC ADVISORY COMMITTEE

The recently appointed advisory committee to Michigan's Emergency Maternal and Infant Care program met at the Michigan Department of Health, Lansing, on June 22. The committee includes: L. Fernald Foster, M.D., Bay City; Campbell Harvey, M.D., Pontiac; Lafon Jones, M.D., Flint; George Kamperman, M.D., Detroit; C. G. Keyport, M.D., Grayling; P. T. Ledwidge, M.D., Detroit; L. V. Ragsdale, M.D, Butterworth Hospital, Grand Rapids; H. M. Smith, M.D., Lansing; Clarence Toshach, M.D., Saginaw; W. D. Towsley, M.D., Midland; Sister Mary William, St. Joseph's Mercy Hospital, Pontiac.

MOSQUITO SURVEY

In connection with the usual summer resort sanitation work the Bureau of Engineering plans a mosquito survey of the state for this summer. Six of the resort sanitarians will devote the entire summer to making this survey to determine types, breeding places, distribution and density of mosquitoes in Michigan. The information obtained will be used largely to determine the control measures that may be necessary for sporadic outbreaks of malaria should they occur, and to furnish some information on the value of pest control. Five additional resort sanitarians will devote their time to the usual resort and trailer coach park sanitation program.

EDUCATION PROGRAM FOR DENTISTS

During the four weeks, ending June 23, Continuing Education Programs for Dentists were presented in nineteen centers in the state under the joint sponsorship of the Michigan Department of Health, Michigan State Dental Society, and the Graduate Dental School of the University of Michigan.

TUBERCULOUS VETERANS REPORTED

Under a recent ruling of the Veterans Administration, all admissions and discharges from Veterans Tuberculosis Facilities are reported to the department of health in the state where the facility is located. These state health departments, in turn, report to the health department of the state which the Veteran has given as his permanent address.

Many such reports of admissions and discharges are now being received in the Michigan Department of Health. A file is being maintained in the Bureau of Tuberculosis Control, and the original data is forwarded immediately to the fulltime local health officer.

No statistics are available at this time as to the number of discharges of Michigan Veterans against medical advice, but it is generally known and accepted that this number is very high. Statistics quoted by Louis Dublin, Third Vice-president and Statistician, Metropolitan Life Insurance Company, show that only three per cent of the patients discharged from veterans' hospitals were medically rehabilitated. We quote Doctor Dublin as follows:

"The remainder of the cases were discharged as 'condition improved' 32.7 per cent; 'condition unimproved' 28.9 per cent; 'dead' 19.5 per cent; and 'condition not stated' 16 per cent."

It is strongly recommended that prompt hospitalization, through ordinary civil channels, be arranged for Veterans requiring hospitalization for tuberculosis.



WHEN *Sensitive Skin* IS DUE TO COSMETICS

Symptoms are often alloyed when offending allergens are removed. Prescribe AR-EX Cosmetics —free from known irritants and allergens.

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FREE FORMULARY

DR.....

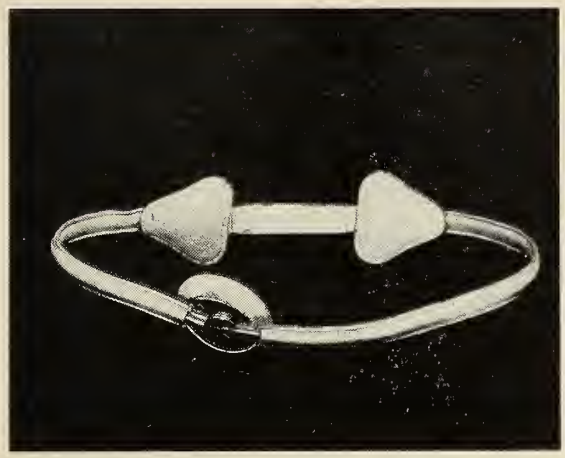
ADDRESS.....

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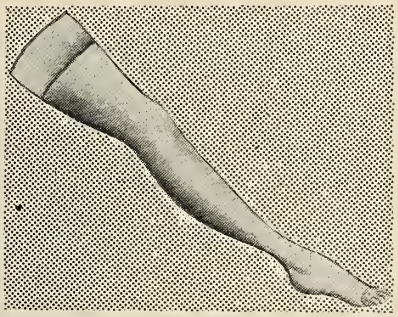
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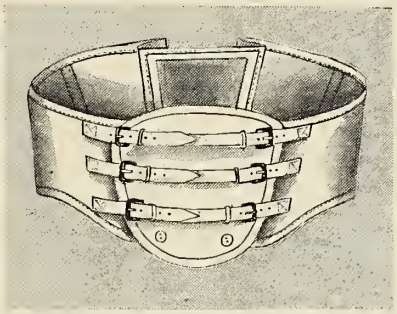
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Woman's Auxiliary

1944 AUXILIARY CONVENTION, GRAND RAPIDS

The Woman's Auxiliary to the Kent County Medical Society has arranged a splendid program of entertainment for all the members and wives of the doctors attending the convention of the Michigan State Medical Society being held in Grand Rapids in September.



Mrs. John J. Walch

The Eighteenth Annual Convention of the Woman's Auxiliary to the Michigan State Medical Society is being held Wednesday and Thursday, September 27 and 28, in the Pantlind Hotel, Grand Rapids. Social gatherings and prominent speakers will add variety to the business sessions.

The registration desk will be located on the Ballroom balcony and will be staffed Tuesday afternoon to Friday afternoon. Please register upon arrival. Read your program, wear your badge, and speak to every other badge wearer—irregardless of a previous formal introduction. The management is providing a hospitality room where you can meet friends, secure information, and relax.

Start now to plan for this gathering. All doctors are in need of both a vacation and a résumé of matters pertinent to their profession. You will welcome an opportunity to make many new acquaintances, renew friendships, and obtain an idea of just what the doctor's wife should know about current affairs.

Make your hotel reservations now.

The officers of the Woman's Auxiliary to the Michigan State Medical Society and the Kent County Medical Society have thoughtfully planned for your pleasure. Whether or not the convention is a success for you, depends on YOU. Come prepared with a bag full of happy anticipations. Welcome all the women you meet. This is YOUR convention! Attend all the affairs planned. The hostesses have allowed ample time for shopping and sight-seeing, so that it will not be necessary for you to miss the meetings.

It is most important that you become informed about the newest approaches approved by the Medical Society in the discussion of the Murray-Wagner-Dingell Bill.

Meet all your old friends at Convention, make new ones, and have fun!

Mary Nee Walch, *President*

* * *

I am very happy for the opportunity afforded me to extend a most cordial invitation to all auxiliary members, also the wives and guests of physicians present at the Michigan State Medical Society Annual Session, to participate in the social functions and attend the sessions of the eighteenth annual meeting of the Woman's Auxiliary to the Michigan State Medical Society. Annual meetings have a way of sounding very dull and with this thought in mind your officers and committee chairmen are busy with plans to make this year's an occasion long to be remembered by each of you who give us the pleasure of being your host. Headquarters will be in the Pantlind Hotel where all meetings will be held.

Bessie P. Dixon
Convention Chairman

* * *

AMA AUXILIARY MEETING

The following are the delegates who registered at the National Auxiliary Convention in Chicago in June: Mrs. Willis Dixon, Grand Rapids; Mrs. Donald Wright, Flint; Mrs. Wm. B. Hubbard, Flint; Mrs. H. A. Ramsdell, Manistee; Mrs. Sherman E. Andrews, Kalamazoo; Mrs. Homer Stryker, Kalamazoo; Mrs. J. H. Burley, Port Huron; Mrs. Wm. Sherman, Detroit; Mrs. L. G. Christian, Lansing; Mrs. H. L. French, Lansing; Mrs. A. V. Wenger, Grand Rapids; Mrs. L. E. Himler, Ann Arbor; Mrs. R. H. Alter, Jackson; Mrs. F. M. Dunn, Jackson; Mrs. Thos. Hackett, Jackson; Mrs. Michael Murphy, Cadillac; Mrs. G. Tornberg, Cadillac; Mrs. H. J. Masselink, McBain; Mrs. T. R. Laughbaum, Lake City; Mrs. John J. Walch, Escanaba; Mrs. Merrill Wells, Grand Rapids.

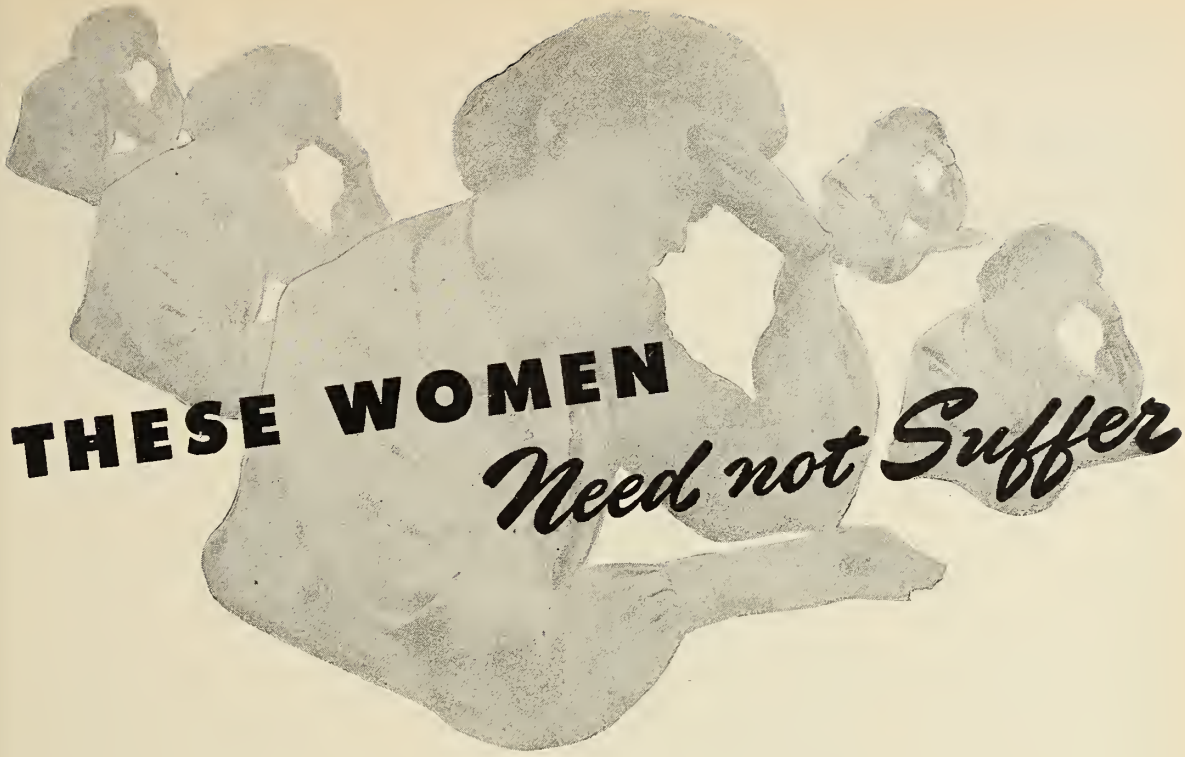
Mrs. Wm. J. Butler, Grand Rapids, who has served as a Director for several years and as a member of the Finance Committee, was also on the Nominating Committee.

The meeting was very well attended. It was interesting and entertaining. The most important business transacted was the adoption of a new constitution. Mrs. Thomas, the new President, assured us that she will be with us for our Annual Banquet. The Michigan delegates enjoyed being together at every opportunity. The convention consisted of the Board of Directors meeting Monday, June 12, business meetings Tuesday and Wednesday with luncheons, a visit to the medical exhibit in the Museum of Science and Industry in Jackson Park followed by a dinner there and a lecture on the contribution medicine has made to aviation. The last *Bulletin* will give the exact program.

—Subscribe to the Bulletin—

Will the County Presidents please send to Mrs. John J. Walch any additional names for the 1943-1944 Necrology List? Following are those submitted to date: Mrs. F. T. Andrews, Lansing; Mrs. Genevieve L. Davey, Lansing; Mrs. Edward A. Duffy, Detroit; Mrs. Wm. G. Quigley, Detroit. These counties reported no deaths:

(Continued on Page 702)



THESE WOMEN *Need not Suffer*

FOR SOME WOMEN the climacteric is practically uneventful except for the cessation of menstrual function. To others the cessation of ovarian activity becomes a crisis to themselves and their families.

One of the valued contributions of endocrinology was the discovery and isolation of potent estrogens and their usefulness in alleviating the distressing symptoms of the menopause.

Within the last five years the natural estrogens have decreased in cost while orally administered diethylstilbestrol costing only one or two cents a day has brought estrogenic therapy within the reach of every woman.

The Squibb Laboratories supply the *natural* estrogens Amniotin, in a variety of dosage forms for use orally, intravaginally or by hypodermic injection. The present price of Amniotin in Oil in capsules is the lowest in history; for injection, Amniotin in Oil in the vial packages makes the cost per dose relatively inexpensive and enables the physician to vary the dosage to fit the patient's requirements.

Diethylstilbestrol Squibb is available in a like variety of dosage forms except that for oral administration it is supplied in tablets rather than capsules. Reports in the literature indicate that, where excessive dosage is avoided, many patients acquire a tolerance to the drug and are able to take it without discomfort.

For literature address the Professional Service Dept., 745 Fifth Ave., New York 22, N. Y.

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(Continued from Page 700)

Bay, Kent, Calhoun, Jackson, St. Clair, Grand Traverse, Saginaw, Wexford, Delta.

* * *

All County Presidents for 1943-44 will be expected to read and submit a report of their activities at the Pre-Convention Executive Board and Annual Meeting, September 27 and 28. These reports should be typewritten, double-spaced, in duplicate (one copy filed with State Secretary after reading and one filed with County Secretary), and limited to three minutes' reading time. Page 15 of the *Handbook* contains the outline to be followed.

* * *

Mrs. John J. Walch attended the annual meeting of the Executive Board of the Michigan Nursing Council for War Service in Lansing on May 19. This is the first time the Auxiliary has been represented on this Board. The report of the assistance rendered by the Auxiliary in the Nurses Cadet Corps work was favorably received.

* * *

In the eighth annual *Hygeia contest,* St. Joseph County (Mrs. D. M. Kane, President) won "Honorable Mention" and Wayne County (Mrs. Wm. L. Foster, *Hygeia* chairman) was listed among those counties which have reached or exceeded their quotas and have at least twenty-five subscription credits.

* * *

Congratulations to Mrs. Don R. Wright of Genesee County for being first to forward a complete list of officers and committee chairmen for 1944-45.

* * *

From the splendid reports that were sent the President to assist her in the preparation of her report for the National Convention it can readily be seen that the suggestions adopted at the Post-Convention meeting for the year's program were well carried out. Although most counties have completed their regular meetings for the year, much work remains to be done by individuals throughout the summer in regard to the defeat of socialized government. Be sure and thoroughly instruct your children and friends who are in college; supply them with literature; get kits of information to all libraries, and contact as many teachers as possible. There is a real need of education along this line.

* * *

Your Program Chairman, Mrs. Galen B. Ohmart, suggests you include *Burma Surgeon* by Gordon Seagrave, *Baby Doctor* by Dr. Abt, and *These Are the Times* by Clare Jaynes in your list of summer reading.

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DIACTOL

In Memoriam

DIED IN MILITARY SERVICE

Martin Batts, Jr., of Grand Rapids was born in 1908 and was graduated from the University of Michigan Medical School in 1933. After serving at Mayo Clinic for two years, Doctor Batts returned to the University and in 1941 received a Master of Science, Surgery, degree. He was commissioned a Captain in the U. S. Army in 1942 and was made a Major in 1943 just prior to going to Australia. He was a member of the American Academy of Orthopedic Surgeons. While in the New Guinea Campaign he contracted acute myelogenous leukemia. He was returned to Letterman General Hospital in San Francisco and then to Percy Jones Hospital, Battle Creek, where he died on July 8, 1944.

James U. Allen of Benton Harbor was born in 1892. He was graduated from Rush Medical College in 1923, and served his internship at Providence Hospital, Chicago. Doctor Allen served eighteen months in the U. S. Army in World War I, after which he practiced Medicine for several years in Grand Rapids. For the past twenty years he practiced in Benton Harbor, where he was on the Staff of Mercy Hospital. He died in Providence Hospital, Chicago, on July 3, 1944.

Charles Harper Baker of Bay City was born in Hillsdale, December 18, 1859. He was graduated from the University of Michigan Medical School in 1882. He practiced in Hillsdale for a short time, then located in Bay City in 1883.

Doctor Baker did postgraduate medical work in Berlin, London, New York and Philadelphia in his specialty of eye, ear, nose and throat work.

Doctor Baker served as a Councilor of the State Society for eight years, and as President of the State Society in 1919-20. He was elected an Emeritus Member of the MSMS in 1942. He died July 8, 1944.

John Thomas Burns of Kalamazoo was born September 16, 1888, in Kalamazoo, and was graduated from Notre Dame University in 1913 and received his Medical Degree at the University of Michigan in 1917. He began practice in Kalamazoo in 1920. Doctor Burns served as a First Lieutenant in World War I, being overseas with Base Hospital No. 98 from November, 1918, to September, 1919. Upon his return, Doctor Burns practiced medicine in Kalamazoo until the time of his death on June 25, 1944.

Edmund F. Collins of Detroit was born in 1889 and was a graduate of the University of Western Ontario Medical School in 1912. In 1916 he came to Detroit to be First Assistant Resident Physician at Grace Hospital and had been a Director of the Hospital since 1927 and was elected Treasurer in 1943.

Doctor Collins was a member of the American College of Hospital Administrators, a life member of the American Hospital Association and the American Congress on Obstetrics and Gynecology, and was associated with many other hospital and medical groups. Doctor Collins died June 29, 1944.

John H. Gilpin of Cheboygan was born in 1876 in Berry, Ontario. He was graduated from the University of Michigan Medical School in 1902. Doctor Gilpin was a Captain in World War I, and was wounded in the Battle of the Argonne. He received the Purple Heart and the Award of the Silver Star.

Before locating in Cheboygan, Dr. Gilpin was in charge of the Indiana Veterans' Hospital at Lafayette for five years.

Early this year Dr. Gilpin was appointed Director of the District Health Department. After a long illness, he died in Community Memorial Hospital June 22, 1944.

John T. Murphy, of Toledo, a member and Past President of the Detroit Roentgen Ray and Radium Society, died June 15, 1944. Dr. Murphy was well known to many Michigan physicians: he was guest essayist on the MSMS General Assembly at the Annual Session of 1937; he was on the program of the Upper Peninsula Medical Society at the Escanaba meeting. Dr. Murphy was Secretary of the Section on Radiology of the AMA, Past President of the American Roentgen Ray Society and of the American Radium Society. He also was Past President of the Toledo Academy of Medicine and a Fellow of the AMA, ACP, Radiological Society of North America, and a Diplomate of the American Board of Radiology which he helped to organize. At the time of his death, Dr. Murphy was Director of the Radiological Department of St. Vincent's Hospital, Toledo, which position he had held since 1917.

In commenting upon his death, caused indirectly by his researches in roentgenology, the *Toledo Blade* editorialized:

"He had saved thousands of lives, yet lost his own. He was a living example of the age-old truth which says that if a man would save his life, he must lose it for others.

"No one ever will remove from medical science, the contribution he has given the world for all time. His life represents a great and permanent stride in the march of medicine toward its goal—to heal and comfort the sick."

Wilbur F. Reed of Cheboygan was born in Pontiac on November 4, 1850. He was graduated from the University of Michigan Medical School in 1877. From

(Continued on Page 706)

Announcement . . . .

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(Continued from Page 704)

then until 1881 he was physician at Ionia Prison, then practiced in Maple Rapids for six years. In 1887 Dr. Reed located in Cheboygan, where he was City Health Officer for eighteen years and Coroner for many years.

Doctor Reed was elected an Honorary Member of the State Society in 1931. He was active in many civic and fraternal organizations until the time of his death on June 30, 1944.

James W. Scott of Detroit was born near Glasgow, Scotland, on July 1, 1868. He was graduated from the Michigan College of Medicine, Detroit, in 1896 and began his practice in Sandusky, Michigan. Later he was in charge of the medical staff of the Michigan Home and Training School at Lapeer. Doctor Scott came to Detroit sixteen years ago where he was in general practice until his death at Mt. Carmel Mercy Hospital on June 25, 1944.

William A. Repp of Detroit was born in New York, December 22, 1872. He was graduated from Detroit College of Medicine in 1895. For twenty years he was Clinical Professor of Gynecology at the Detroit College of Medicine. He was Attending Physician and Surgeon at St. Vincent's Orphanage for eleven years, and was Consulting Gynecologist at the Florence Crittenden Hospital. In 1891 Dr. Repp was given charge of St. Mary's Hospital Dispensary and has been with that institution ever since. Doctor Repp died June 19, 1944.

Harry B. Weinburgh of Lansing was born in Boston on March 21, 1882. He was graduated from the University of Illinois Medical School in 1911. During World War I he served as a Lieutenant overseas for two years. Until 1935 he served as a Major in the U. S. Army Reserve Corps.

Doctor Weinburgh specialized in eye, ear, nose and throat in Lansing for twenty years. He died June 29, following an illness of several weeks.

The Michigan State Board of Registration in Medicine will hold examinations in Detroit on Monday, Tuesday and Wednesday, September 25, 26, and 27.

In Lansing

HOTEL OLDS

Fireproof

400 ROOMS

Say you saw it in the Journal of the Michigan State Medical Society

The macrocytic anemias in pregnancy respond to

Solution LIVER EXTRACT *Lederle*



MACROCYTIC ANEMIAS in pregnancy resemble other macrocytic anemias. This type of anemia frequently responds best to a complete antipernicious anemia regime, including the injection of liver extract, vitamin therapy, a diet adequate in protein, and iron by mouth when there is evidence of hypochromia.

REFINED SOLUTION LIVER EXTRACT *Lederle* is a potent preparation of the antianemia substance which, because of exceptional care and expense in preparation, causes a minimum of discomfort at the time of injection. Use of this liver extract may be expected to result in a prompt reticulocytosis, a progressive reversal of the abnormal erythrocyte picture, and simultaneous correction of symptoms.

PACKAGES:

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(3) 1-10 cc. vial (10 U.S.P. XII injectable units per cc.)

SOLUTION LIVER EXTRACT

(4) 3-3 cc. vials (10 U.S.P. XII injectable units each vial)

SOLUTION LIVER EXTRACT CONCENTRATED

(5) 3-1 cc. vials (15 U.S.P. XII units each)

(6) 1-10 cc. vial (150 U.S.P. XII units)

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COUNTY AND PERSONAL ACTIVITIES

About $3,750,000,000 will be needed to pay interest on the federal debt in the fiscal year beginning July 1, 1944!

* * *

The Michigan State Board of Registration in Medicine, at its June, 1944, meeting, revoked the licenses of Martin B. Robinson and Frederick W. Thomas, Detroit physicians who were convicted on criminal offenses.

* * *

During the first three months of 1944, 26,115 babies were born in Michigan. This compares with 30,260 births during the first ninety days of 1943. This decrease is general throughout the country.

* * *

To many a war-weary and travel-worn veteran, social security will mean the opportunity to settle down in a home of his own. Will his plans to meet payments on a home take account of unexpectedly high social insurance deductions from earnings?

* * *

EMIC Statistics.—15,638 applications were made in Michigan to June 1, 1944; 1,894 Doctors of Medicine are coöperating; the average cost per patient in April was $77.32 for obstetrical care and $50 for pediatric care; 211 institutions have been authorized to render service, including 191 medical hospitals.

* * *

The Michigan Pathological Society held its regular bi-monthly meeting on May 27, 1944, at Eloise Hospital. The scientific session was devoted to a seminar on "Lesions of the Mouth" and was conducted by Dr. D. A. Kerr of the Department of Pathology, University of Michigan. Forty-seven members and guests were present.

* * *

Conrad R. Lam, M.D., Detroit, is the author of an original article "The General Care of the Burned Patient" which appears in JAMA of June 24.

In the same issue appears "The Problem of Thermal Burns" by Henry N. Harkins, M.D., formerly of Detroit and now of Baltimore, Maryland.

* * *

Postgraduate credits.—Michigan Doctors of Medicine who have taken postgraduate courses outside the State are invited to advise H. H. Cummings, M.D., Department of Postgraduate Medicine, University Hospital, Ann Arbor, in order that proper credit may be received toward Fellowship or Associate Fellowship in postgraduate medicine, Michigan State Medical Society.

* * *

Postgraduate course in otolaryngology.—The University of Illinois College of Medicine announces a didactic and clinical refresher course for specialists in otolaryngology to be held at the College September 25 to 30 inclusive. For information write the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk St., Chicago 12, Illinois.

* * *

"The Doctor Fights."—The radio presentations sponsored by the Schenley Laboratories every Thursday evening at 9:30 E.W.T., were the subject of a vote of congratulation made by the Executive Committee of The Council of the Michigan State Medical Society at its June 22 meeting.

"The Doctor Fights" should be heard by every Doctor of Medicine in the United States who in turn should urge his patients to "listen in."

* * *

Wilfrid Cowan, M.D., Detroit won the Handicap Championship of the American Medical Golfing Association at its 29th Annual Tournament, Flossmoor Country Club, Chicago, on June 12. Dr. Cowan was awarded the Detroit Trophy which was presented by the Hosts at Detroit in 1916.

Another Michigan winner was F. C. Bandy, M.D., of Sault Ste. Marie, who won the Radiological Section Trophy.

* * *

"Bureaucracy Runs Amuck" is a title of a book by Lawrence Sullivan which has been published in a condensed and up-to-the-minute revision in Hearst newspapers. The condensations are distributed by King Features Syndicate, Inc. On May 28 the column was headed "Cites Perils of Socialized Medicine, Plan Would Put All Doctors Under U. S.; End Practices."

On May 29: "The Smear Campaign Against Private Medicine."

The book and condensations are copyrighted by Bobbs-Merrill Co.

* * *

EMIC Program.—At the hearing before the U. S. House Committee on Appropriations, May 3, re the proposed appropriation of $42,800,000 for EMIC for the fiscal year ending June 30, 1945, the following statement was made by Representative Carver of Georgia:

"It seems to me that your Bureau 'U.S. Children's Bureau' is anxious to supervise the entire matter and tell the doctor exactly how he shall handle the case, what sort of professional service is to be rendered, and have entire supervision over the whole thing. I can see no necessity for that."

* * *

Increase in ages for service with Veteran's Administration.—Physicians up to the age of sixty-three will be commissioned by the Army for service with the Veteran's Administration, and physicians up to the age of fifty-five will be commissioned by the Navy for similar service. Doctors of Medicine desiring to serve in the Veteran's Administration may be commissioned by the Army for assignment to serve with the Veteran's Administration only. Physicians so commissioned must undergo physical examination but are not required to undergo examination on scientific subjects.

* * *

The Michigan Pathological Society willl meet in Grand Rapids on the occasion of the Annual Session of the Michigan State Medical Society.

The pathologists have arranged a program for

Wednesday, September 27, in the Grill Room of the Pantlind Hotel, beginning with the luncheon of the Section on Pathology at 12:00 noon. The Scientific Program will be presented between 2:00 and 4:00 p.m., in the Grill Room, followed by the MSMS Discussion Conference on Pathology.

Dinner will be served at the Blodgett Memorial Hospital at 6:00 p.m. with the final meeting of the Society at 7:30 p.m., at the hospital.

M. O. Alexander, M.D., Blodgett Memorial Hospital, Grand Rapids, is in charge of arrangements.

* * *

Radio Committee presentations during July, over WJR, were:

July 6—Dr. Robert C. Bassett, Instructor in Surgery in the University of Michigan Medical School: The Problem of Epilepsy.

July 13—Dr. Leonard E. Himler, Assistant Professor of Mental Health in the University of Michigan and Associate Psychiatrist in the University Health Service: Mental Hygiene Aspects of Industrial Rehabilitation.

July 20—Dr. H. Marvin Pollard, Assistant Professor of Internal Medicine in the University of Michigan Medical School: Gas.

July 27—Dr. Frank F. A. Rawling, Instructor in Internal Medicine in the University of Michigan Medical School: Allergy.

* * *

The Michigan Chapter of the American College of Chest Physicians has elected the following officers: President, G. L. McClellan, M.D., F.C.C.P., Detroit; Vice president, Arthur R. Young, M.D., F.C.C.P., Pontiac; Secretary-Treasurer, William P. Chester, M.D., F.C.C.P., Detroit.

The Michigan Chapter will hold its next meeting in conjunction with the annual meeting of the Michigan State Medical Society in Grand Rapids on Thursday, September 28.

For further particulars concerning the meeting, please communicate with Dr. William P. Chester, Secretary-Treasurer, Michigan Chapter, American College of Chest Physicians, 2916 Seminole Avenue, Detroit.

At the annual meeting of the American College of Chest Physicians held at Chicago, June 10-12, William A. Hudson, M.D., Detroit, was reëlected as the Governor of the College for Michigan for a term of three years. Dr. Hudson was also reëlected as Chairman of the Board of Governors.

* * *

A bill to transfer all health activities now in the U. S. Department of Labor to the U. S. Public Health Service has been introduced into the Federal Congress by Congressman A. L. Miller of Nebraska. The number of Doctor Miller's bill is H.R. 4663.

Congressman Miller has also introduced H.R. 5128 providing for the deferment of 6,000 medical and premedical students and also proposing the deferment of 4,000 dental students annually. The 1944 AMA House of Delegates adopted the following resolution on this

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subject: "Whereas, The present policy of the Army and the Selective Service System in preventing the enrollment of a sufficient number of qualified medical students will inevitably result in an over-all shortage of qualified physicians with imminent danger to the health and well-being of our citizens, therefore be it

Resolved, That it is imperative that immediate action be taken by the President of the Congress of the United States to correct the current drastic regulations which result in a restriction of the number of students qualified to enter the courses of medical instruction in approved medical schools."

* * *

MSMS PUBLIC RELATIONS RADIO HOUR

Listen to the twenty-six five-minute dramatized sequences of an educational nature depicting the public benefits and proposed medical availabilities—as contrasted to federal-bureaucratic-compulsory forms of medical practice.

This MSMS program runs a period of thirteen weeks beginning August 1 over

WXYZ,	Detroit	WIBM,	Jackson
WBCK,	Bay City	WHDF,	Calumet
WJIM,	Lansing	WFDF,	Flint
WSOO,	Sault Ste. Marie	WKTZ,	Muskegon
WOOD,	Grand Rapids	WDBC,	Escanaba
WELL,	Battle Creek	WDMJ,	Marquette

The presentations were arranged by the MSMS Public Relations Committee and particularly by the Advisory Committee on Radio, C. L. Candler, M.D., A. S. Brunk, M.D., P. L. Ledwidge, M.D., and C. R. Keyport, M.D. Fred R. Reed, M.D., is Chairman of the Public Relations Committee.

MEDICAL SERVICE PLANS OPERATED IN CO-OPERATION WITH BLUE CROSS PLANS

(Enrollment as of January 1, 1944)

Name of Plan	Total Participants
California Physicians' Service, San Francisco	90,000*
Colorado Medical Service, Denver	10,620
Group Hospital Service, Inc., Wilmington, Del.	11,569
Massachusetts Medical Service, Boston	22,166
Michigan Medical Service, Detroit	608,655
Surgical Care, Inc., Kansas City, Mo.	6,254
Medical-Surgical Plan of New Jersey, Newark	16,015
Western New York Medical Plan, Buffalo	20,089
Community Medical Care, Inc., New York City	37,561
Medical and Surgical Care, Inc., Utica, N. Y.	22,626
Hospital Savings Association, Chapel Hill, N. C.	39,371
Medical Service Association, Durham, N. C.	13,391
Medical Service Assn. of Pa., Pittsburgh, Pa.	8,717

*Estimated.

* * *

"SOCIALIZING THE PUBLIC"

Recently a businessman accosted a friend who said: "Well, Doctor, I see where they are going to socialize your business under the Federal Security Act."

The Doctor, who had spent his life helping the ill and afflicted in his community, regardless of their financial circumstances, said: "Oh no, my friend, they are going to socialize you. When the Federal government takes six per cent of your earnings and six per cent from your employer on wages paid you up to a specified amount, tells you what doctor to go to, when, and where, you will be getting the benefits of socialism, not me. When that day comes I will go back to pipe fitting, which is just working with a different kind of pipes than those in a human."

Yes, it's the public, not the doctors, that would suffer

Say you saw it in the Journal of the Michigan State Medical Society

from politically appointed physicians. There would no longer be incentive for the better doctors to carry on. An independent pipe fitter would have more future than a socialized doctor.

—*The Lowell Ledger,* Lowell, Michigan

* * *

APPROVAL OF PRESCRIPTIONS FOR HEAVY CREAM

On June 2, 1944, the War Food Administration issued Amendment 2 to War Food Order 13. This amendment requires, among other things, that medical prescriptions for heavy cream be approved by the public health officer or the secretary of the county medical society of the area where a patient or hospital is situated. War Food Order 13 has heretofore provided for the prescription of heavy cream for use in the treatment of the sick under certain conditions. Amendment 2 now adds the provision requiring approval by public health officers or secretaries of county medical societies.

The new provision, which became effective on August 1, 1944, is contained in paragraph (c)(1) of the order and is as follows:

"*Provided further,* That such written statement shall not be valid for obtaining such cream after July 31, 1944, unless approved by the public health officer, or the secretary of the county medical society, of the municipality or county wherein such patient resides or such establishment is located."

In adopting the new provision for approval of medical prescriptions for heavy cream, the War Food Administration does not in any way attempt to instruct health officers or secretaries of county medical societies as to the cases or ailments for which prescriptions for heavy cream should be approved. This is being left entirely to their own judgment. If the advice received from medical authorities that there are only a few cases requiring heavy cream is correct, the new provision should place little burden on public health officers and secretaries of county medical societies. It was on this premise that the provision was adopted.

* * *

MCCC OFFERS POLIOMYELITIS CONSULTATION SERVICE AGAIN THIS YEAR

We are again approaching the summer months and the beginning of the poliomyelitis season. In order that every child who is suspected of having or has poliomyelitis may receive care and treatment, members of the Michigan State Medical Society are urged, where the family is unable to finance the treatment, to have the child avail himself of the treatment facilities offered through the Michigan Crippled Children Commission.

In order that every child may be given the opportunity for care and treatment of this infection at the earliest possible moment, and thereby reduce the possibilities of deformity and contractures, the Commission is establishing the poliomyelitis consultation service to physicians again this year. This service is offered by the Commission with the coöperation of members of the State Medical Society, the Secretaries of the local



● Comb of caponized white leghorn in regressed state.



● Same capon showing increase in size of comb after repeated injections of Virosterone.

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county medical societies and the full-time county health officers.

Pediatric and orthopedic consultation is offered to the physician in suspected cases or established cases of poliomyelitis in children from birth to twenty years of age inclusive where the family is financially unable to provide the service, and where such consultation service is not furnished locally.

The local physician desiring this consultation, should get in touch with the secretary of his county medical society or full-time city, county, or district health officer and supply him with information as to the need of consultation, whether such consultation is desired from a pediatric or orthopedic standpoint, and his choice of consultants from the approved list of the consultants in his area.

The secretary of the county medical society or health officer should wire the Michigan Crippled Children Commission, collect, giving the name of the family physician, the name of the consultant selected, and the name of the patient. Upon receipt of such request the Commission will wire direct to the consultant chosen authorizing the consultation service.

While medical science continues its research to discover the causative agent of this disease, the Michigan Crippled Children Commission with the coöperation of the members of the State Medical Society, is extremely interested in seeing that every child who has this infection is given the opportunity for consultation and proper care and treatment.

Say you saw it in the Journal of the Michigan State Medical Society

CORRESPONDENCE

June 8, 1944

Dr. Wilfrid Haughey, Editor:

Dr. Frank F. Tallman, who has been Director of Mental Hygiene in the State of Michigan for the past two and one-half years, is resigning to accept the position of Commissioner of Mental Diseases in the Ohio State Department of Public Welfare, Columbus.

There are fifteen hospitals for the mentally ill, feebleminded, and epileptic in the Division of Mental Diseases which Dr. Tallman will supervise, with a population of about 27,000 patients. In addition to his work with the hospitals, Dr. Tallman will be responsible for a receiving hospital program, and a state-wide program of mental hygiene.

Department of Public Welfare
HERBERT R. MOONEY, *Director.*

To the Editor:

DECLARATION OF MEDICAL POLICIES

"The launching of State controlled plans for medical care without consulting the vitally important parties, the Doctors of Medicine, is evidence that the advocates are more interested with bureaucratic domination than with improving the quality of Medical care.

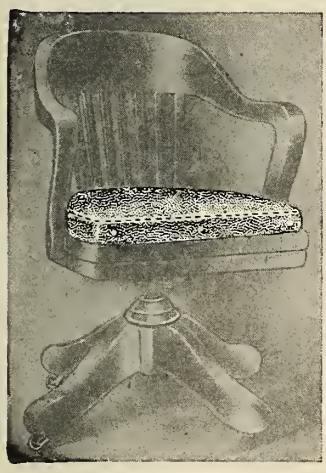
"We encourage the presentation of ideas for improvement of medical care by any individual or organization; but any plan of medical care inaugurated without the study and approval of Doctors of Medicine will be considered an unfriendly act.

"We, the undersigned, pledge ourselves that in a postwar, free America, we will not accept regimentation of the medical profession."

Do you remember the above proclamation? It was presented to the House of Delegates of the Michigan State Medical Society and duly approved at the September meeting, 1943. We were of the opinion that anyone *with the right to call himself a member of the Michigan State Medical Society* would be delighted to support such a frank statement of policies. *"Anybody with the right to call himself a member,"* was what we wrote.

You say it, "I am a member of the Michigan State Medical Society," and we'll say, "Prove it!" Oh, don't show us your membership card. We know you have one. Prove it to your conscience. How? By doing quickly and efficiently anything that will aid the cause for which a very few of your fellow members are working so hard. It would seem to us that signing the above declaration would be one definite way to prove you *are* a member. Let's get those signatures in before the Michigan State Medical Society House of Delegates meets in September, 1944. With that kind of backing our Council can go to the U. S. Children's Bureau or any other organization, be it governmental

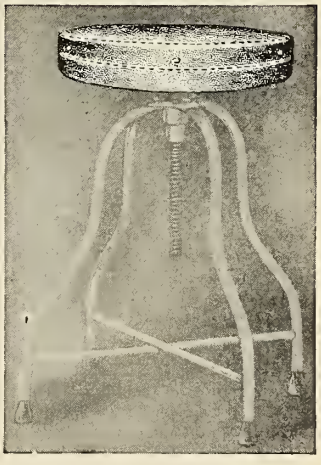
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or otherwise and say, "Your plans for distribution of medical care must be submitted for study and approved by the doctors of medicine of Michigan before you will receive coöperation." With that sort of backing we need not fear revolutionary changes in medical care as proposed in the Murray-Wagner-Dingell Bill or any other like legislation. It will leave us free to find out what is the best type of medical care and eventually see that everyone gets it in the American way. We already have the finest type of medical care in the world today. Let us improve it and make it available to all.

What kind of member are you?

What does your conscience say? Is this a good idea? Then sign the declaration and know you are doing something worth while. We have already signed.

C. E. UMPHREY

Mutual Benefit Health and Accident Association of Omaha
Omaha, Nebraska
Gentlemen:

Recently we received a letter from the Wayne County Medical Society, 4421 Woodward at Canfield, Detroit, one of our component societies, which contained the following paragraph:

"A. H. Lange, M.D., Chairman of the Insurance Studies Committee of the Wayne County Medical Society, and this office have been telephoned by several members in the last week who report that representatives of the Mutual Benefit Health & Accident Association of Omaha, in their solicitations are creating the impression that they have a special group policy approved by the Michigan State Medical Society. The advertisement that appeared in the April issue of your JOURNAL is an essential part of this alleged misrepresentation. Inasmuch as you state that your Council has not approved any particular insurance company or policy but feel this is a prerogative of the local societies, and also, inasmuch as the W.C.M.S. has a special group policy approved by the Council of this organization, written by the Continental Casualty Company of Chicago, the contacts being made by the representatives of the Mutual Benefit Company are leading to considerable confusion and thereby resulting in a waste of very valuable time on the part of busy practitioners in this area.

"We do not wish to give the impression in this letter that we are in any way opposed to the representatives of any insurance company in the world calling upon and attempting to sell the individual members of this Society, but we are interested in stopping, if it does exist, any injurious misrepresentation."

This communication from the Wayne County Medical Society was presented to the Executive Committee of The Council of the Michigan State Medical Society at its May 24 meeting, and thoroughly discussed.

The Executive Committee of The Council instructed that a letter be dispatched to you containing the above information from the Wayne County Medical Society, and further stating that the Michigan State Medical Society has not approved the policy of any insurance company, which approval or disapproval is the prerogative of the county medical societies; only the advertising of the Mutual Benefit Health & Accident Association of Omaha has been accepted for the MSMS JOURNAL.

The Executive Committee of The Council would ap-

Say you saw it in the Journal of the Michigan State Medical Society

preciate your taking whatever steps you deem advisable to eliminate any misunderstandings among members of the Wayne County Medical Society that may have resulted due to statements allegedly made by your representatives, either intentionally or otherwise, to the effect that the Michigan State Medical Society has approved your health and accident insurance policy.

We appreciate your coöperation in this matter and your early reply to transmit to the Insurance Studies Committee of the Wayne County Medical Society.

Yours very truly,
MICHIGAN STATE MEDICAL SOCIETY
L. FERNALD FOSTER, M.D., *Secretary*

June 3, 1944

Dr. L. Fernald Foster, Secretary,
Michigan State Medical Society,
2020 Olds Tower,
Lansing 8, Michigan.

Dear Doctor:

The fair and courteous way in which you called attention to the situation in Wayne County with reference to some solicitation attributed to representatives of our Association is deeply appreciated, and we assure you of our earnest coöperation toward the end that our representatives may continue their enrollments strictly on the merits of our proposition without creating or leaving any erroneous impression as to approval by the State Society.

We are fortunate in having in Michigan a state manager of the highest ethics and integrity, and so are passing your letter along to Manager E. B. Brink who can be depended on to put back into the proper channels any representative who might have gone too far in his enthusiasm for the product that he has been offering.

Our Association is headed by Doctors of Medicine and our coöperation with the physicans and medical societies all over the country has been so splendid that we do not want anything to occur anywhere which would in any way jeopardize those fine relations which we have enjoyed for so many years.

Yours very truly,
MUTUAL BENEFIT HEALTH & ACCIDENT ASSN.
S. C. CARROLL, *Vice President.*

June 6, 1944

Dr. L. Fernald Foster, Secretary
Michigan State Medical Society
2020 Olds Tower
Lansing 8, Michigan

Dear Doctor Foster:

Mr. S. C. Carroll, our Vice-President at Omaha has forwarded to the writer the letter you wrote him on the 6th: and I want to assure you, doctor, of our desire to keep our business on the highest plane and to see that our salesmen do not in any way misrepresent the product they are offering.

We have called a meeting of the men who are offering this special policy to the medical groups: and have

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The pathologist in direction is recognized by the Council on Medical Education and Hospitals of the A. M. A.

also called Mr. Bechtel of the Wayne County Medical Society. He is arranging a meeting of their Insurance Studies Committee, and I hope we can run this thing down.

We'll write you further, doctor, as soon as we have something more to report.

Very truly yours,
MICHIGAN BRANCH OFFICE
E. B. BRINK, *State Manager*

June 10, 1944

POLIOMYELITIS

(Continued from Page 678)

patients can walk without any artificial supports or limp, or toe drop. The limb is affected from the pelvis to the toes, but the thigh is flexed and the leg extended; and the patient does not hurry off the flail leg. Could this be achieved ever with the physical therapy taught in Minneapolis, which has been admittedly raised to a very fine art, if the cell was totally destroyed? We know the muscle has been destroyed, for we can see it. Could it be that the motor pattern or correct movement of the skeleton is still controlled? These are added questions that remain to be answered by the medical world. The evidence can be produced at any time to any group or individual. Who can supply the answer?

Recurrence or Reinfection

I have in my experience come in contact with seven cases of recurrence, after a period of years has elapsed. The second attack has always been more severe than the first. I have also seen many cases of reinfection. The patient may present the symptoms and be diagnosed as definite infantile paralysis with the conditions of spasm, incoördination, alienation and denervation present. The patient may be responding satisfactorily to treatment for perhaps several days and perhaps on some occasions weeks. The patient will then become very much more painful. Spasm will recur in areas hitherto apparently free and become more painful and pronounced in the areas first infected. These latter cases are the patients who are left more severely handicapped. We have in our experience been able to restore to normal a very high percentage of cases where this reinfection has not occurred.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

INFECTIONS OF THE PERITONEUM. By Bernhard Steinberg, M.D., Director of Toledo Hospital Institute of Medical Research; Foreword by Frederick A. Coller, M.D., Director Department of Surgery, University Hospital, Ann Arbor, Mich. New York: Paul B. Hoeber, Inc. 1944. Price $8.00.

This highly scientific work represents 18 years of intensive study, laboratory and clinical research by Dr. Steinberg. Most of the book is devoted to the clinical aspects of infections of the peritoneum of all types, and has useful information for the practitioner as well as the surgical specialist.

Considerable attention is given to the basic sciences, bacterioligy, pathology, and physiology, which lead to a better understanding of the broad field of peritoneal infections. Many controversial questions and procedures are well analyzed. Although there is some repetition, this tends to stress important features of the diagnosis and treatment of peritonitis.

Dr. Steinberg has striking clinical results with colibactragen, and other antitoxins supplemented by the use of the sulfonamides. Sound surgical principles are stressed throughout the text, and an extensive bibliography is presented.

SMALL COMMUNITY HOSPITALS. By Henry J. Southmayd, Director, Division of Rural Hospitals, The Commonwealth Fund, and Geddes Smith, Associate, the Commonwealth Fund. New York: The Commonwealth Fund, 1944.

This book is published to give small communities the benefit of experience in establishing small hospitals. Many problems must be met in financing, organization, By Laws, Staff organization, etc. These have been met by other groups and such studies and experiences are used to set forth the advice given here, rather than to experiment. Many suggestions are made relative to organization, rates, the plant, and plans for a small community fifty-bed hospital. The American College of Surgeons' minimal standards are given with suggested By Laws and rules and regulations.

THE PSYCHOLOGY OF WOMEN: A Psychoanalytic Interpretation. By Helene Deutsch, M.D., Associate Psychiatrist, Massachusetts General Hospital; Lecturer, Boston Psychoanalytic Institute. Foreword by Stanley Cobb, M.D., Bullard Professor of Neurology, Harvard University. Volume One. New York: Grune & Stratton, 1944. Price $4.50.

Doctor Deutsch has a prolific knowledge of women, their doings and why they do it. This book is a comprehensive study of the psychic life of women, analyzing their every thought and action. It is in the nature of the study of a developing young person. The next volume will continue that study. To the student of such problems and to the consultant who must solve the intricate questions presented by a growing mind which may be slightly abnormal this book gives the answer.

THE MANAGEMENT OF NEUROSYPHILIS. By Bernhard Dattner, M.D., Jur.D., Associate Clinical Professor of Neurology, New York University Medical College; with the Collaboration of Evan W. Thomas, M.D., Assistant Professor of Medicine and Associate Professor of Dermatology and Syphilology, New York University Medical College and Ger-

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MEDICINE—Two-Week Course in Internal Medicine starts October 16.

GYNECOLOGY—Two-Week Intensive Course starts October 2. One-Week Course in Vaginal Approach to Pelvic Surgery starts October 23.

OBSTETRICS—Two-Week Intensive Course starts October 16.

ANESTHESIA—Two-Week Course in Regional, Intravenous and Caudal Anesthesia.

GASTROSCOPY—Personal Course starts October 16.

OTOLARYNGOLOGY—Two-Week Intensive Course starts October 2.

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trude Wexler, M.D.,; Instructor in Dermatology and Syphilology, New York University Medical College. Foreword by Joseph Earl Moore, M.D., Associate Professor of Medicine and Adjunct Professor of Public Health Administration, Johns Hopkins University, New York: Grune and Stratton, 1944. Price $5.50.

The author, a teacher in Vienna before the present European situation, here presents a survey of all methods of diagnosis and management of syphilis of the central nervous system. He gives the results of case studies in mass, as interpreted by his own vast experience. He gives methods of taking observations and tests, and the reasons for the conclusions reached. He has given an unusually clear and comprehensive study of all methods of treatment evaluating them and giving the application and results. There is an inclusive review of important contributions in the entire field, and 37 pages of references. Since all neurosyphilitic patients cannot be treated by a specialist, this book serves as a clear and comprehensive reference text for the internist or the practitioner who has the case. The language is delightful, making study a pleasure.

OFFICE ENDOCRINOLOGY. By Robert B. Greenblatt, B.S., M.D., C.M., Professor of Experimental Medicine, University of Georgia School of Medicine; Director Sex Endocrine Clinic, University Hospital, Augusta, Georgia. With a foreword by G. Lombard Kelly, M.D., Dean, University of Georgia School of Medicine. Springfield, Illinois, and Baltimore, Maryland: Charles C. Thomas, 1944. Price $4.00.

The author gives office practices and theories of treatment of most diseases of women, as well as obesity, sterility, in their glandular relations. A chapter is given on acne in adolescence. Pituitary, gonads, the estrogens, the male climacteric, all are treated. The book is interesting, and will undoubtedly be useful. Its preparation represents a tremendous amount of labor.

FUNCTIONAL DISORDERS OF THE FOOT, Their Diagnosis and Treatment. By Frank D. Dickson, M.D., F.A.C.S., Associate Professor of Clinical Surgery, Medical School, University of Kansas; Orthopedic Surgeon, St. Lukes', Kansas General and Wheatly Hospitals, Kansas City, Mo., and Providence Hospital, Kansas City, Kansas, and Rex L. Diveley, A.B., M.D., F.A.C.S., Colonel, Medical Corps, Army of the United States, Orthopedic Consultant, European Theatre of Operations, etc. 202 Illustrations. Second Edition. Philadelphia, Montreal, London: J. B. Lippincott Company, 1944. Price $5.00.

The authors have produced a second edition in five years, and have given clear discussions of the treatment and diagnosis of the things happening to the foot. Anatomy, etc., is given as a matter of course, also the application of appliances, the methods of correcting deformities, and stresses and imperfections before they become deformities. The relation of military service is given, and the relation of the foot to industry, The book is a delight in its handiness, its readability and its scope of conditions treated.

ÆSCULAPIUS IN LATIN AMERICA. By Aristides A. Moll, Ph.D., Secretary-Editor of the Pan American Sanitary Bureau, Washington, D. C. 639 pages with 179 illustrations. Philadelphia and London: W. B. Saunders Company, 1944. Price $7.00.

Doctor Moll has produced a very complete history of medicine from the earliest recorded times up to the present in what is now Latin America. He discusses the origin of culture and life itself in America, and the advances in medicine. He writes of the doctors of the early expeditions, the diseases encountered, the skill of the pre-Columbian races who had a knowledge of rubber syringes, trephining, embryotomy, embalming, cre-

Say you saw it in the Journal of the Michigan State Medical Society

nation, operative measures for pterygium, bone setting, bleeding, circumcision, reducing dislocations, amputations, etc. He discusses the supposed origin in America of syphilis, and yellow fever and suggests that syphilis is a variety of yaws which had been known in Africa for a long time.

The Badianus manuscript written in Aztec in 1552 was the first American Pharmacopœia. Hospitals were established and flourishing in Latin America 160 years before any in our own part of the world. There are chapters on the various specialties, military medicine, the training of physicians. Many of the leaders in medical thought and advancement are written up, and a chapter on Social Security as far back as the Inca period. With the increased travel opportunities due to the war and its advancement of interests in all peoples we will have much more contact with medicine in Latin America, and this book is a storehouse of information of the past and present. It is interestingly written, well presented, and makes a handbook for interrupted reading.

ALLERGY IN PRACTICE. By Samuel M. Feinberg, M.D., Associate Professor of Medicine and Chief of the Division of Allergy, Northwestern University Medical School; President, American Association for the Study of Allergy, 1942-3; with the Collaboration of Oran C. Durham, Chief Botanist, Abbott Laboratories, Chicago: The Year Book Publishers, Inc., 1944. Price $8.00.

The author has made this a very practical book on Allergy. It is not too elementary, and yet is simply stated and contains free and sufficient discussions of the problems to be a real aid. The practical and accepted features are set in large type and the controversial, theoretical and experimental material is presented in smaller type, not too small to be easily read, but sufficient to call attention to the difference. The role of molds in allergy is especially stressed as would be expected from the fact that the author was the first to stress this importance. Twenty per cent of the book is devoted to the discussion of individual allergies not related to asthma and hay fever. Attention is called to the fact that many specialists must deal with allergy, such as the dermatologist, rhinologist, ophthalmologist, neurologist, orthopedist, cardiologist, gastro-enterologist, pediatrician, obstetrician and even the surgeon. Each of these fields is fairly well covered in various parts of this book. Diets and preparation of extracts have been presented in much detail. We are very much pleased with the book, from the standpoint of good clear presentation, brevity, and readability.

BOND GOAL EXCEEDED

The $16,000,000,000 Fifth War Loan exceeded its goal by $4,639,000,000, establishing a new record for a war-financing operation. Plans now are being made for the Sixth War Loan. It may open November 11, Armistice Day, and close December 7.

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INDEX TO ADVERTISERS

Ar-Ex Cosmetics, Inc. 698

Barry Allergy Laboratories, Inc. 716
Becker, Otto K. 702
Bernheim Distilling Co., Inc. 638
Burroughs Wellcome & Co. 633

Camel Cigarettes 654
Camp, S. H., & Co. 627
Canada Dry Ginger Ale, Inc. 709
Central Laboratories—Detroit 720
Central Laboratory—Saginaw 716
Cheplin Biological Laboratories, Inc. 647
Ciba Pharmaceutical Products, Inc. 697
Insert, facing page 640
Classified Advertising 702
Clinical Laboratories 718
Coca-Cola Co. 710
Commercial Solvents, Inc. 630, 631
Cook County Graduate School of Medicine 717
Crane Discount Corporation 718
Cummins Optical Co. 705

DeNike Sanitarium 718

Ferguson-Droste-Ferguson Sanitarium 715

General Electric X-Ray Corporation ..... Inside Back Cover
Glidden, Otis E., & Co., Inc. 639
Green Lake Rest Home 706

Hack Shoe Co. 655
Harrower Laboratory 712
Hartz, J. F., Co. 699
Holland-Rantos Co., Inc. 640
Hotel Olds 706

Ingram, G. A., Co. 711

Lederle Laboratories, Inc. 707
Lilly, Eli, & Co. 656

M. & R. Dietetic Laboratories, Inc. 642
Mead Johnson & Co. ..... Back Cover
Medical Protective Co. 696
Medical Supply Corporation 717
Merck & Co., Inc. 648
Milwaukee Sanitarium ..... Back Cover
Mutual Benefit Health & Accident Co. 712

Parke, Davis & Co. 643
Philip Morris & Co., Ltd., Inc. 652
Plessner, Paul, Co. 703

Randolph Surgical Supply Co. 645
Rupp & Bowman Co. 719

Schenley Laboratories, Inc. 653
Schmid, Julius, Inc. 650
Searle, G. D., & Co. 641
Smith, Kline & French Laboratories 629, 644
Squibb, E. R., & Sons 635, 701
Stearns, Frederick, & Co. 625
Stokes Sanitarium 719
Stroh's 719

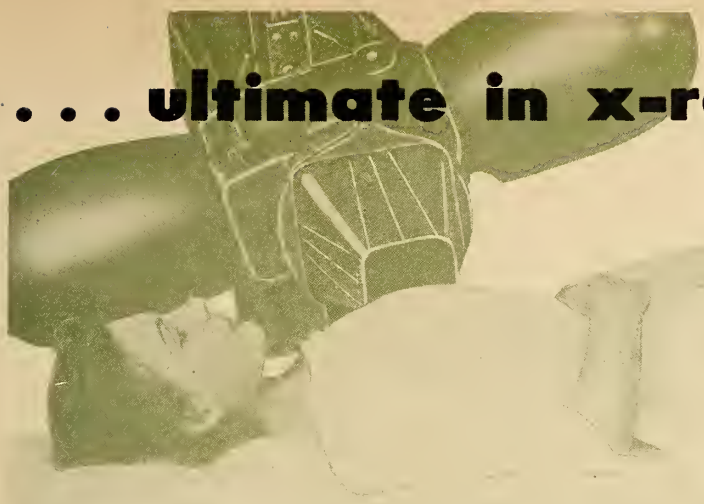
Vanol Chemical Co. 649

Wander Co. 646
Wehenkel Sanatorium 714
Whaling's 695
White Laboratories, Inc. 637
Winthrop Chemical Co., Inc. 651
Wocher's 713
Wyeth, Inc. ..... Inside Front Cover

Zemmer Co. 69

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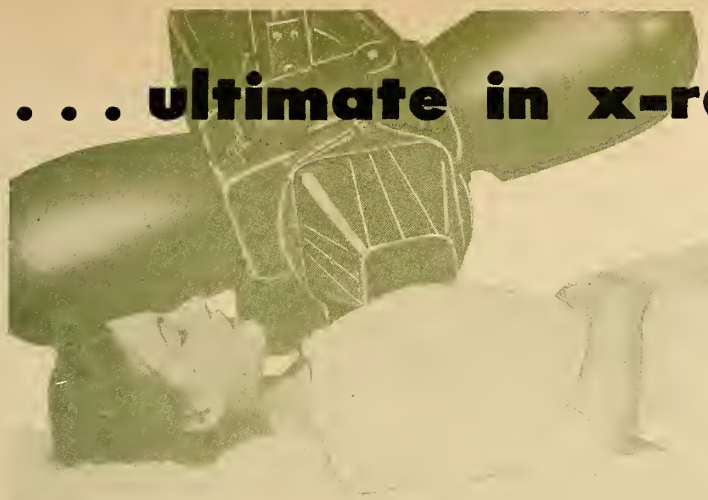
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YOU AND YOUR BUSINESS

EMIC PROGRAM—PURE FEDERAL MEDICINE

"Of importance in the mind of the Executive Board of the American Academy of Pediatrics is the underlying thought and philosophy of those at present administering the U. S. Children's Bureau, and the obvious intent of the Bureau under the guise of a war emergency to secure for itself a permanent postwar place in medical practice in the United States." This quotation from the editorial in *The Journal of Pediatrics,* July, 1944, expresses the sentiment of many doctors of medicine and their medical societies throughout the United States. Not only the American Academy of Pediatrics but the American Medical Association and most of the state medical societies in these United States have voiced objections to the present conduct of the EMIC Program by the Children's Bureau.

The Special Committee on EMIC Program, appointed by the Michigan State Medical Society, presented the following report to the MSMS Council in July concerning its unsuccessful attempts to negotiate with the Children's Bureau:

"The 1943 House of Delegates of the Michigan State Medical Society passed two resolutions relative to the EMIC Program. The first expressed its disapproval of the program as presently operating, and the second instructed this Council to negotiate further for a more satisfactory arrangement.

"In accordance with this instruction the special EMIC committee (Drs. Keyport, Foster, and Ledwidge) working with representatives of the Executive Committee of Michigan Medical Service and Michigan Auditor General Vernon S. Brown, and assisted by Drs. V. M. Moore and C. E. Umphrey worked out a plan for disbursement of EMIC funds to coöperating physicians through Michigan Medical Service.

"The plan was approved by the Board of Directors of MMS and rejected by the Chief of the Children's Bureau.

"This refusal of the Chief of the Children's Bureau to approve the plan was conveyed to Dr. Lillian R. Smith of the Michigan Department of Health by letter, dated February 8, 1944 and signed by Dr. Edwin F. Daily. In this letter Dr. Daily quoted at length from a verbose opinion written by Mr. Peter Seitz, a solicitor for the Children's Bureau. We quote only the opening sentence of this opinion which seems to portend the verdict of the solicitor and to indicate the attitude of the Children's Bureau; and is therefore significant: 'You have requested my opinion on the question whether you have the authority to *refuse to approve* an amendment to the plan of the State of Michigan under the EMIC program.'" (Italics are ours.)

The EMIC Committee requested Dr. Smith to invite to Michigan Dr. Martha M. Eliot of the Children's Bureau for a meeting with representatives of Michigan State Health Department, MSMS, and MMS.

The meeting with Dr. Martha Eliot was held in Detroit, June 8. Those present were: Martha Eliot, M.D., and Solicitor Peter Seitz from the Children's Bureau; Commissioner Wm. DeKleine, M.D., and Lillian Smith, M.D., from the Michigan Department of Health; J. C. Ketchum, Drs. Keyport, Brunk, Moore, Insley, Foster, Umphrey, Novy, and Ledwidge who acted as Chairman; and Wm. J. Burns who acted as Secretary.

The whole EMIC program was discussed; the plan for disbursements through MMS was resubmitted, including the assignment forms which had been approved by Auditor General Brown. Dr. Eliot told us that the Children's Bureau will continue to oppose direct allotments to soldiers' wives. Mr. Seitz stated that there was no precedent of the Bureau delegating any of its administrative duties to a non-governmental agency and that therefore it could not be done, although the whole original EMIC program in the State of Washington was set up without precedent. It seems that the Chief of the Children's Bureau has plenty of discretionary power when setting up a program, but is a stickler for precedent and "the intent of the Congress" when changes in her program are suggested. Just how she determined "the intent of the Congress" months before Congress had expressed itself is not clear.

Dr. Eliot agreed to again present the plan to her Chief for reconsideration. We have not been advised of any further action or change in attitude, and we doubt if any will be forthcoming.

The following data are interesting:

1. The case load in Michigan is averaging from 1,000 to 1,100 per month, a total up to June 1 of 15,638, which number includes both obstetric and pediatric cases.

2. Now coöperating in the Michigan plan are 1,894 M.D's and 305 osteopaths. Under a Children's Bureau ruling the osteopaths are limited to obstetric care only.

3. The over-all EMIC federal case load runs about 40,000 per month.

4. Available for this program for the fiscal year ending June 30, 1944: $29,700,000. For the fiscal year beginning July 1, 1944, Congress has appropriated $42,800,000, of which not more than 2 per cent may be used for administrative purposes.

* * *

PRACTICE OF MEDICINE BY HOSPITALS

"Is it lawful in Michigan for a hospital to contract for its pathologists to do the work of another hospital?"

This question has been asked in two instances recently.

If a corporation or a layman contracts to supply the services of a pathologist (or of any doctor of medicine) to another organization or corporation and profits financially thereby, then the transaction involves an engagement in the field of Medicine.

The principle is the same as that which was under discussion by the AMA House of Delegates in 1943 re

(Continued on Page 728)



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YOU AND YOUR BUSINESS

(Continued from Page 726)

relationships between radiologists and hospitals (JAMA, June 19, Page 526). A hospital cannot practice medicine, nor can any corporation or any layman.

The "Principles of Relationship Between Hospitals and Radiologists, Anesthetists, and Pathologists" by Victor Johnson, M.D., covers this whole question. Copies may be procured by writing the Council on Medical Education and Hospitals, American Medical Association, 535 N. Dearborn St., Chicago 10, Illinois.

DEFERMENT OF PREMEDICAL STUDENTS

"Whereas, The present policy of the Army and the Selective Service System in preventing the enrollment of a sufficient number of qualified medical students will inevitably result in an over-all shortage of qualified physicians with imminent danger to the health and well-being of our citizens; therefore be it

"*Resolved,* That it is imperative that immediate action be taken by the President or the Congress of the United States to correct the current drastic regulations which result in a restriction of the number of students qualified to enter the courses of medical instruction in approved medical schools."

This Resolution, adopted by the AMA House of Delegates in June, 1944, speaks of a most serious problem facing the medical profession of the country, one which is a direct threat to the health of the people in future years.

Congressman L. E. Miller, Missouri, recently introduced H.R. 5027 into the Federal Congress providing for the deferment in each calendar year of not less than 6,000 medical and premedical students. This bill is pending in the House Committee on Military Affairs.

Congressman Paul W. Shafer of Battle Creek is a member of this important committee. Letters from members of the Michigan State Medical Society to Mr. Shafer, urging the use of his influence in behalf of Dr. Miller's bill, are indicated.

* * *

MICHIGAN HEALTH COUNCIL

After a number of months devoted largely to formulation of purposes and methods, the Michigan Health Council now has begun its formal existence with incorporation as a non-profit agency and the opening of offices at 1402 Washington Boulevard Building, Detroit.

The Michigan State Medical Society together with the Michigan Hospital Association, provides both the direct and the indirect sponsorship of the new agency.

It is felt that the Health Council can perform a highly important function by coördinating matters of mutual interest to the two Societies and to such others as may eventually join with them, by conducting studies related to the health needs of the people, by forwarding an educational program for the public, and by recommending measures which may contribute to the improvement of health services.

Of basic interest to the Health Council at present is the status of prepayment plans in relation to the public, the medical profession and the hospitals. Controversy over the issue of voluntary versus compulsory prepayment obviously has arisen as the result of increasing public concern with the economics of medical and health care.

The Health Council will be in a position to accumulate the facts regarding this situation and to relay them to the profession and the public. Already it has initiated a study of the matter, calling in a disinterested outside agency for that purpose; the results of the survey will be reported at the MSMS Annual Session in Grand Rapids on September 28, 1944. If the survey is as competent as it promises to be, it will, for the first time, provide the factual material which is essential in charting a sound course for the future.

As a working organization, the Michigan Health Council is operated by a panel of ten members or representatives from the sponsoring societies. The Michigan State Medical Society is represented directly by three Council members and indirectly by the two members nominated by the Society's affiliate, Michigan Medical Service. Similarly, the Michigan Hospital Association has three and Michigan Hospital Service has two Council representatives. It is possible that other related societies or agencies ultimately may also wish representation, and means for accepting this wider representation have been left open.

A. S. Brunk, M.D., of Detroit, president-elect of the Michigan State Medical Society, is president of Michigan Health Council. As its treasurer, the Council elected Jay C. Ketchum, executive vice president of Michigan Medical Service. Members of the Council are:

Representing the Michigan State Medical Society: A. S. Brunk, M.D., of Detroit; C. E. Umphrey, M.D., of Detroit; and Wm. J. Burns of Lansing. Representing the Michigan Hospital Association: Graham L. Davis, of Battle Creek; L. V. Ragsdale, M.D., of Grand Rapids; L. S. Woodworth, M.D., of Detroit. Representing Michigan Medical Service: R. L. Novy, M.D., and Jay C. Ketchum, both of Detroit. Representing Michigan Hospital Service: William J. Griffin and W. H. Lichty, both of Detroit.

* * *

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Charles F. Kettering, General Motors vice president in charge of research, will be the final banquet speaker at the three-day annual meeting of the Association of American Medical Colleges in Detroit next October 23-25.

This is the first time during its seventy-five-year history that the Wayne College of Medicine has acted as host to the Association. The Association voted to come to Detroit because of nation-wide interest in the projected Medical Science Center. The Association has as members the seventy-five Class A medical schools of the United States and Canada. More than 300 leaders in the medical teaching and practice fields will come to Detroit for the annual meeting, and more than a thousand will attend sessions.

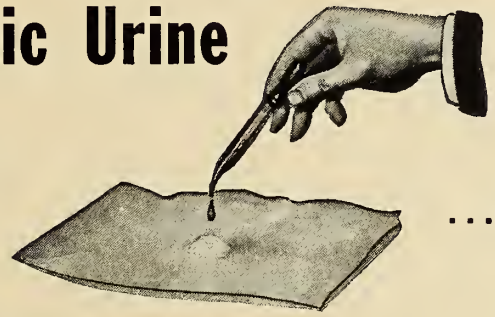
Among the Detroiters who will address the annual meeting are Drs. Clark D. Brooks, Burt R. Shurly, Muir I. Clapper, Harry L. Clark, Daniel Hasley, Gordon B. Myers, Warren E. Bow, David D. Henry.

(Continued on Page 730)

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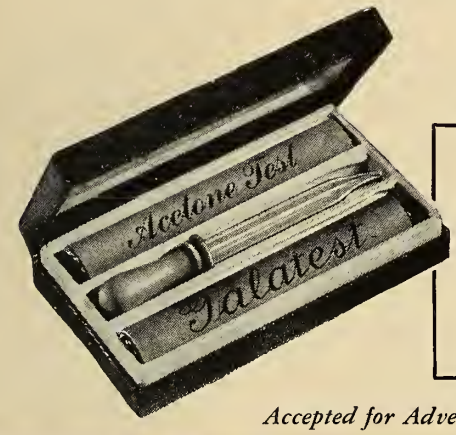


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THE BEAUMONT GAVEL

Carved out of the only piece of timber which has ever been allowed to be taken from the Early House on Mackinac Island, where Dr. William Beaumont performed his revolutionary physiological experiments, the Beaumont Gavel was presented to The Council of the Michigan State Medical Society by the Mackinac Island State Park Commission at Mackinac Island on July 21, 1944. In presenting the Beaumont Gavel, Wilfred F. Doyle, Chairman and Resident Commissioner of the Mackinac Island Park Commission, stated that the pure white pine in the Gavel was grown and cut on the Island and used in the original structure of the Early House where Alexis St. Martin was carried after his gunshot wound and where Beaumont first called upon and made many visits to his remarkable patient.

Mr. Doyle outlined the development of "Astor Street" on the Island and told of the improvements being made each year in the medical, political and commercial, historical landmarks. He reported that the Early House had been purchased through a generous $10,000 grant made by Parke Davis & Company and A. W. Lescoheir, M.D., its president. He explained the plans to put the building into shape as a museum and memorial to William Beaumont, M.D.

Mr. Doyle recommended the appointment of a permanent committee, representing the Michigan State Medical Society, the Beaumont Foundation, and the Mackinac Island State Park Commission, to insure maintenance of the Beaumont shrine and continued interest in this historical spot where great medical progress was originated.

In making the actual presentation of the Beaumont Gavel to The Council, Mr. Doyle stated: "We of the State Park Commission are happy to work with the Michigan medical profession on something of which we all will be very proud."

The Beaumont Gavel was accepted with thanks by Chairman V. M. Moore, M.D., on behalf of The Council. He stated that this Gavel will be handed down from one Council Chairman to another and kept sacred as long as the medical profession of Michigan exists.



PRESENTATION OF THE BEAUMONT GAVEL

W. F. Doyle (standing), Chairman and Resident Commissioner of the Mackinac Island State Park Commission, presents the Beaumont Gavel to The Council of the Michigan State Medical Society through its Chairman, V. M. Moore, M.D., (seated, second from right). Others seated are President-Elect A. S. Brunk, M.D., and President C. R. Keyport,, M.D. Standing, left to right: Secretary L. Fernald Foster, M.D., Speaker of the House of Delegates P. L. Ledwidge, M.D., Chairman of the Publication Committee R. S. Morrish, M.D., Chairman of the Finance Committee C. E. Umphrey, M.D., Editor Wilfrid Haughey, M.D., Chairman of County Societies Committee E. F. Sladek, M.D., and Vice Chairman of The Council O. O. Beck, M.D.

MATERNITY MORTALITY STUDY IN MICHIGAN

The Michigan State Medical Society, through its Committee on Maternal Health, will begin a five-year mortality study commencing January 1, 1945. A review will be made of all deaths associated with pregnancy and childbirth in the state.

This proposed study has been approved by The Council of the Michigan State Medical Society. The Division of Vital Statistics of the Michigan Department of Health will assist in this research.

It is hoped that a careful analysis of maternal deaths will stimulate greater interest in maternal care not only among the physicians but in the hospitals and maternity

(Continued on Page 738)

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(*Sulman, L. D., 1943; Silcox, L. E. and Schenck, H. P., 1942.*)

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Autumn, 1944

The Michigan State Medical Society, in coöperation with the University of Michigan Medical School, Wayne University College of Medicine, the Michigan Department of Health, and the Wayne County Medical Society, announces the extramural postgraduate courses for the autumn, 1944.

Centers	Dates
Ann Arbor	October 12 and November 9
Battle Creek	October 3 and 17
Flint	October 10 and November 28
Grand Rapids	October 10 and November 14
Lansing	October 17 and November 21
Mt. Clemens	October 11 and November 8
Saginaw	October 10 and November 14
Traverse City	October 11 and November 13

Subjects

First Day:

Lecture: Penicillin. Indications and Dosage.

Lecture: The Use of Parenteral Fluids.

Lecture: The Recognition and Management of Angina Pectoris and Acute Coronary Occlusion.

Second Day:

Lecture: Acute and Chronic Intestinal Disturbances in Children.

Lecture: Vaginitis, Pruritus, and Kraurosis Vulvae.

Panel Discussion: Urinary Tract Infections.

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The detailed program will be mailed to physicians in the State early in the autumn. For further information, address:

COMMITTEE ON POSTGRADUATE EDUCATION
Room 2040, 1313 E. Ann St.
Ann Arbor, Michigan

FELLOWS AND ASSOCIATE FELLOWS IN POSTGRADUATE MEDICAL EDUCATION—1944

The State Society congratulates the following Doctors of Medicine on their successful completion of the formal continuation work arranged by the MSMS Committee on Postgraduate Medical Education. Certificates of award will be mailed to all Fellows and Associate Fellows shortly after the 1944 Postgraduate Conference on War Medicine in Grand Rapids—the State Society's 79th Annual Session.

The following Doctors of Medicine are eligible for Certificates of Fellowship in Postgraduate Education, Michigan State Medical Society for 1944:

Lewis J. Burch, M.D., Mt. Pleasant; William Lloyd Foust, M.D., Grass Lake; Oswald F. Banting, M.D., Richmond; Roy E. H. Baribeau, M.D., Battle Creek; Charles M. Baskerville, M.D., Mt. Pleasant; George Bates, M.D., Kingston; James C. Droste, M.D., Grand Rapids; Cecil W. Ely, M.D., Saginaw; John A. Engels, M.D., Richmond; Dugald A. Galbraith, M.D., Lansing; Laslo Galdonyi, M.D., Detroit; James W. Gauntlett, M.D., Traverse City; John W. Holcomb, M.D., Grand Rapids; Reader J. Hubbell, M.D., Kalamazoo; Mathias S. Hurth, M.D., Lansing; Ralph S. Jiroch, M.D., Saginaw; Leo A. H. Knoll, M.D., Ann Arbor; George F. Lamb, M.D., Grand Rapids; Robert E. Mills, M.D., Boon; Frank L. Morris, M.D., Cass City; Albert P. Murphy, M.D., Saginaw; O. M. Randall, M.D., Lansing; Wilma C. Weeks-Rorich, M.D., Battle Creek.

Archibald B. Thompson, M.D., Grand Rapids; Morris D. Wertenberger, M.D., Jackson; John W. Wholihan, M.D., Jackson; Melissa H. C. Worth, M.D., Ypsilanti; Oscar H. Bruegel, M.D., East Lansing; James R. Adams, M.D., Dearborn; Charles L. Bennett, M.D., Kalamazoo; Earl Bloomer, M.D., Dearborn; Charles W. Brayman, M.D., Cedar Springs; Jacob H. Burley, M.D., Port Huron; Ralph G. Cook, M.D., Kalamazoo; Ennis H. Corley, M.D., Jackson; James E. Curlett, M.D., Roseville; Lewis H. Darling, M.D., Lansing; Walter den Bleyker, Kalamazoo; Frederick E. Dodds, M.D., Flint; Fred H. Drummond, M.D., Kawkawlin; Thomas E. Fleschner, M.D., Birch Run; Wallace M. Foster, M.D., Detroit; Harold M. Fox, M.D., Portland; William Gadsen Gamble, Jr., M.D., Bay City; Harold H. Gay, M.D., Midland; Charles L. Hodge, M.D., Reading; Edward S. Huckins, M.D., Bay City; Harry G. Huntington, M.D., Howell.

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(Continued on Page 738)

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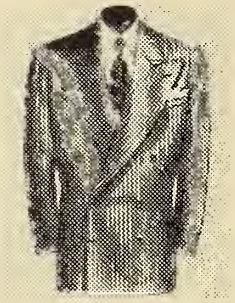
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(Continued from Page 736)

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The following Doctors of Medicine are eligible for Certificates of Associate Fellowship, 1944:

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MATERNAL MORTALITY STUDY IN MICHIGAN

(Continued from Page 730)

homes where such care is given and that it will be of educational value to the laity.

While maternal mortality in Michigan in 1943 was the lowest in the history of the state, it can still be reduced. Such a study should reveal the causes of death and suggest means of prevention.

The State Society desires to obtain the hearty cooperation of all physicians in the state who practice obstetrics. As soon as possible after a maternal death occurs, a representative of the study group will personally interview the attending physician and obtain all pertinent information connected with the death and will also review the hospital records of each case. The question blank when completed will be kept under lock and key by the State Society.

The State Society is sponsoring this enterprise because it believes that it will result in rendering a better type of maternal care in all phases of the work.

Say you saw it in the Journal of the Michigan State Medical Society

Table of Contents

The Health Needs of the Nation as Reflected by Selective Service.
Colonel Leonard G. Rowntree, Med. Res. 769

The Neglected Interns.
Luther R. Leader, M.D. 777

Analysis of Deaths Occurring in Michigan from Pneumonia (All Forms).
A. B. Mitchell, M.D., M.P.H. 779

President's Page:
Medicine Fares Forward 783

Editorial:
1944 Postgraduate Conference on War Medicine .. 782
Andrew P. Biddle 782
The Servicemen's Readjustment Act of 1944 782
Continuing Medical Education 784
History Repeats 785
This Time a Ray of Understanding 785

Grand Rapids, Convention City 786

The 79th Annual Session—1944 Postgraduate Conference on War Medicine:
Official Call 787
Annual Session Information 788
Guest Speakers—Photographs 791
Woman's Auxiliary 792
Official Program 793-800
Scientific Exhibits 801
Technical Exhibits 802
Annual Report of the Council 808
Annual Report of Delegates to AMA 810
Annual Report of Mental Hygiene Committee ... 812
Annual Report of Medical-Legal Committee 812
Proposed Amendments to Constitution and By-Laws 812

Michigan's Department of Health 816

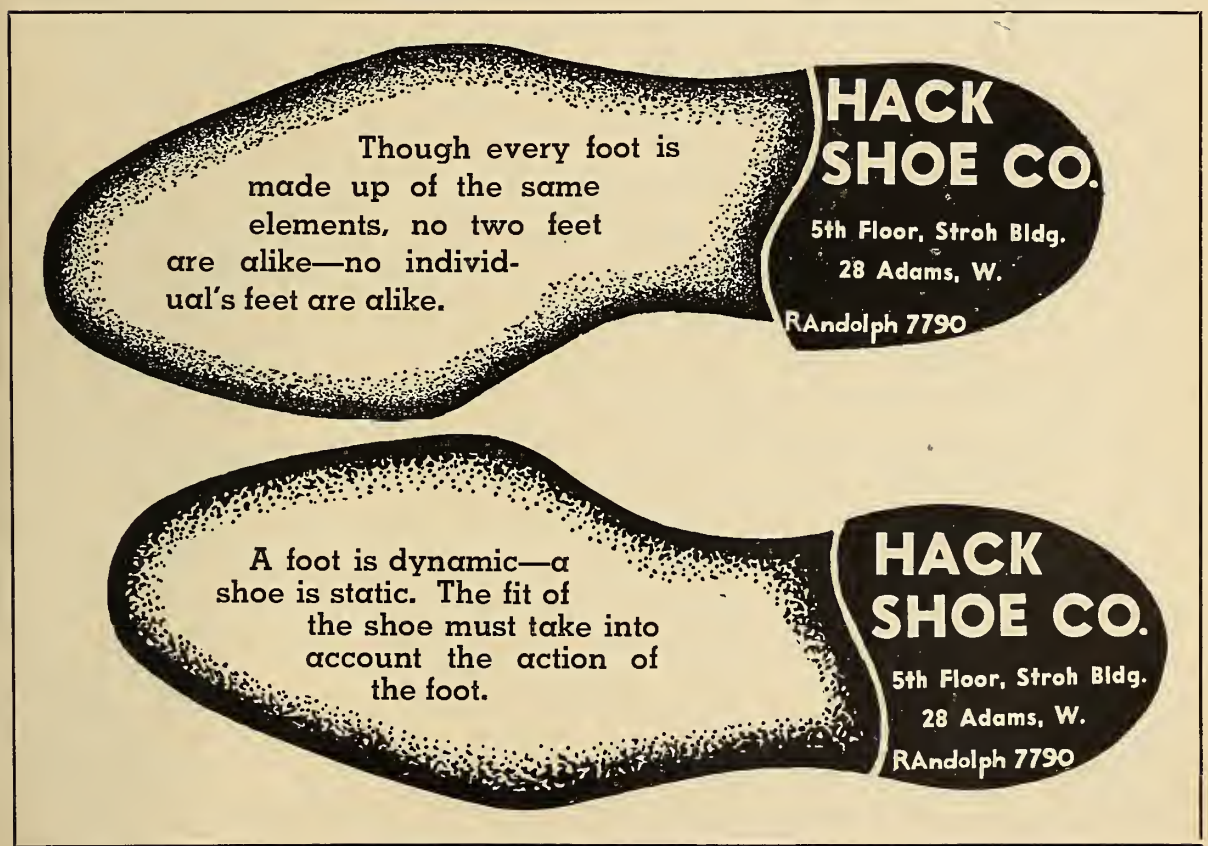
County and Personal Activities 818

In Memoriam 830

The Doctor's Library 832

You and Your Business 726

Michigan Postgraduate Program for Graduates in Medicine 736





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The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

Volume 43 September, 1944 Number 9

The Health Needs of the Nation as Reflected by Selective Service

By Colonel Leonard G. Rowntree, Med. Res.



Chief, Medical Division, National Headquarters, Selective Service System, Vice Chairman, National Committee on Physical Fitness, Federal Security Agency.

■ It is with deep appreciation that Selective Service accepts this opportunity to address the 1943 Postgraduate Conference on War Medicine at the 78th Annual Session of the Michigan State Medical Society. The subject selected is "The Health Needs of the Nation as Reflected by Selective Service."* This is a matter of vital significance to the nation at this time. Honorable Paul V. McNutt, Chairman of the War Manpower Commission, and Major General Lewis B. Hershey, Director, Bureau of Selective Service, are vitally interested in all matters pertaining to the health and welfare of the people. They have ardently supported all conferences that have to do with improvement of health and physical fitness and both have given valuable guidance and much aid in this field.

The situation is essentially as follows: This country is now in the midst of the most gigantic, ruthless, savage struggle of all times. Two basic requirements essential to victory are fighting men and weapons of war. Men and equipment must be superior to those of our enemies in quality and quantity. How can these critical needs be supplied? Both require tremendous manpower. Our population is large and supposedly sufficient for all the needs, but the War Manpower Commission, as well as Selective Service, has long since learned that the manifold demands cannot be met except with rare wisdom in recruitment and placement. The optimal use of manpower necessitates comprehensive visualization of all the problems involved, clear insight as to their actual and relative importance and accurate figures as to the numbers of individuals needed and available for service with the fighting forces and for essential industries. In computing the needs for the military establishment one factor must be kept in mind; namely, that only the healthy and fit can qualify for the fighting forces.

Manpower has two objectives: to supply legitimate demands in all fields and to place every registrant in the position where he can best serve the needs of the nation. Information of the kind needed for these purposes can be obtained only through the aid of statistics. Selective Service has been fortunate to date in that its Division of Research and Statistics has been competent to meet all its major needs. Statistical surveys have been made in many different fields involving manpower problems but it is believed that in none have the findings been more significant to the nation than those relating to the rejections of

Read before the 1943 Postgraduate Conference on War Medicine at the 78th Annual Session of the Michigan State Medical Society, September 23, 1943, Detroit.

*Selective Service has its own Division of Research and Statistics and carries out statistical studies for its own purposes. Their surveys yield only a partial picture of the health of the nation. Only through correlating Selective Service findings with those of other governmental agencies (Army, Navy, U. S. Public Health Service, Veterans Administration, et cetera) are the health needs of the nation revealed in their entirety. By the present contribution an attempt is being made to reflect the general picture as seen through the eyes of Selective Service.

registrants for military service because of physical or mental unfitness.

Such figures depict the health defects of the nation. In this connection therefore Selective Service is functioning as a mirror, reflecting the picture of health and illness of the nation. Now that the picture is available, it should be scrutinized and studied with great care. The nation is at present in an admirable position to visualize its defects, to determine its health needs, and to take many steps toward the improvement of the situation. This has the utmost significance for war needs and also for postwar programs.

In this connection some figures will be of decided interest.

TABLE I

Total population of the United States	130,000,000
Civilian workers	53,000,000
Eligible men registered (18-44)	29,000,000
Eligible men subject to call (18-37)	22,000,000
Registrants examined	13,000,000
Men in service with the fighting forces	9,300,000
Number classified IV-F*	3,500,000

*This does not include the large numbers of men rejected by the Navy prior to February 1, 1943.

These figures speak for themselves. Under no stretch of the imagination can they be taken as indicative of a satisfactory state of health and physical fitness among our registrants. While it is true that many of the disqualifying defects leading to IV-F classification are in some respects minor in nature, yet they represent unfitness for combat duty and constitute a health handicap that stands as a challenge to the nation.

Since so many millions of men are involved in these recent statistical studies, it can be assumed that the figures afford a rather fair index of the actual health condition of the nation as a whole. Let us, therefore, study these reports, see what they have disclosed to date, and what they reflect for the future.

Fortunately, not one but several surveys have been conducted, most of them include incidence of defects as well as rates of rejections for disqualifying defects. The figures have been broken down by age, race, states, occupation and residence (urban vs. rural). The rate of rejection, though of greatest importance in a military sense, is not always the most accurate index of national health and needs, since the rate of rejection varies directly with the height of admission standards. The standards for admission vary in turn with the available pool of manpower and the size and urgency of military needs. As a matter of fact, admission requirements are adjusted constantly (raised or lowered) to insure an inflow of fit men adequate for military duty. The defect incidence rate, therefore, is often the more reliable index of the health of the nation than is the rejection rate.

Statistics are no more reliable than the basic data they cover. The reliability of the clinical diagnoses is enhanced somewhat in the present practice by the fact that double screening is exercised in the examination of men for service. In the first year and a half of operation of Selective Service, the burden of rejection was largely on the Selective Service boards (forty-one of the 50 per cent rejected), while in the last eighteen months it rested with the armed forces induction stations, thirty-five of the 42 per cent now being rejected. Despite the lowering of standards for admission and the changes in examining procedures and examining personnel, the rejection rate remains high.

Medical Statistical Bulletin No. 1

Survey No. 1 deals with the procurement program for the selection and training of a peacetime Army and covers roughly the period from October, 1940, until the attack on Pearl Harbor and America's entrance into the war. During this period admission requirements were relatively high since the available manpower pool was large (at that time considered inexhaustible) and our participation in war a matter of uncertainty. Only the men from twenty-one to thirty-six years of age were accepted, and during the later months only men from twenty-one to twenty-eight years.

The results were surprising and somewhat disheartening. Of the first 2 million men examined, 1 million or 50 per cent were found unfit for service with the Army because of physical or mental defects (900,000) or educational deficiency (100,000). The breakdown was as shown in Table II.

Two-thirds of the registrants physically examined by local boards were between the ages of twenty-one and twenty-seven, inclusive. Registrants between the ages of twenty-eight and thirty-six, inclusive, accounted for 31.3 per cent of the total number examined. Rejections for registrants between the ages of thirty-one and thirty-six, inclusive, were nearly twice as great as that for registrants between the ages of twenty-one and

TABLE II. ESTIMATED NUMBER OF REGISTRANTS UNQUALIFIED FOR GENERAL MILITARY SERVICE BECAUSE OF PHYSICAL AND MENTAL REASONS

Major defect or disease	Total unqualified for general military service	Percentage of estimated total unqualified for general military service
Teeth	188,000	20.9
Eyes	123,000	13.7
Cardiovascular system	96,000	10.6
Musculo-skeletal	61,000	6.8
Venereal	57,000	6.3
Mental and nervous	57,000	6.3
Hernia	56,000	6.2
Ears	41,000	4.6
Feet	36,000	4.0
Lungs (including tuberculosis)	26,000	2.9
Miscellaneous*	159,000	17.7
Total	900,000	100.0

*Including diseases and defects of the mouth and gums, nose, throat-kidneys and urinary system, abdomen, genitalia, and skin; also hemorrhoids, varicose veins, tumors and infectious and parasitic diseases.

twenty-five, inclusive. The rejection rate for urban and for rural areas were essentially the same.

In this survey a total of 27,031 defects was tabulated from the 19,923 reports of physical examination, an average of 1.4 defects per registrant examined. No defects were recorded, however, for 5,741 registrants, or 29 per cent of the total number examined. At least one defect was recorded for 14,182 registrants, an average of 1.9 defects per registrant with defects. Two defects were recorded for 8,433 registrants and three defects were recorded for 4,416 registrants. A maximum of three defects per registrant was tabulated. More than one-half of the registrants qualified for general military service had disqualifying defects.

Medical Statistical Bulletin No. 2

A second survey (Medical Statistical Bulletin No. 2) covered the results of study of a larger group, 3,000,000 registrants, examined through September, 1941. It confirms the results as reported earlier and shows a total rejection rate of 52.8—43.8 per cent at local boards and 9.0 per cent at the Armed Forces Induction Stations.

Negro registrants had higher rejection rates than whites: 59.4 per cent as opposed to 51.9 per cent. Syphilis and educational deficiency in

TABLE III. LEADING CAUSES OF REJECTION

Dental	16.5
Eyes	11.7
Mental and nervous	10.4
Cardiovascular	10.0
Musculo-skeletal	8.9
Hernia	5.9
Venereal disease	5.9
Ear, nose and throat	5.5
Lungs	3.8
Educational deficiency	3.8
Feet	3.0
Underweight	2.9
Other causes	11.7

the Negro were chiefly responsible for the higher rate.

Since age and race play so important a role in the rates of rejection, it is desirable to have a definite statement concerning these factors; the age, height, weight, for whites and Negroes is therefore included.

Incidence of All Recorded Defects.—An average of 1.58 defects was recorded for all registrants examined. This is slightly in excess of the 1.4 average as determined in Survey No. 1.

Significance of Peacetime Survey.—For the nation at large these figures should have permanent significance. Subsequently standards were changed and with them the rejection rates for various defects, but findings in the later surveys do not alter in any way the significance of the earlier survey. For example, both Medical Statistical Bulletin No. 1 and 2 place dental defects first as a cause for rejection. The rate was so high that it engendered public resentment. The dental requirements for admission were lowered. Consequently dental defects practically disappeared from the list of causes for rejection. But this in no way decreased the seriousness of dental defects as a national problem. In fact, the situation was so serious from the military point of view that the Dental Corps of the Army was compelled to develop and operate its own dental rehabilitation program from within. It would appear therefore that the dental situation was too serious to be handled on the outside.

However, this dental rehabilitation program has been limited to the military forces. The situation so far as the civilians are concerned is status quo. The dental problem, therefore, remains one of our chief considerations in any program aimed at improvement in national health.

To obtain some idea of the magnitude of the dental service being rendered currently by the

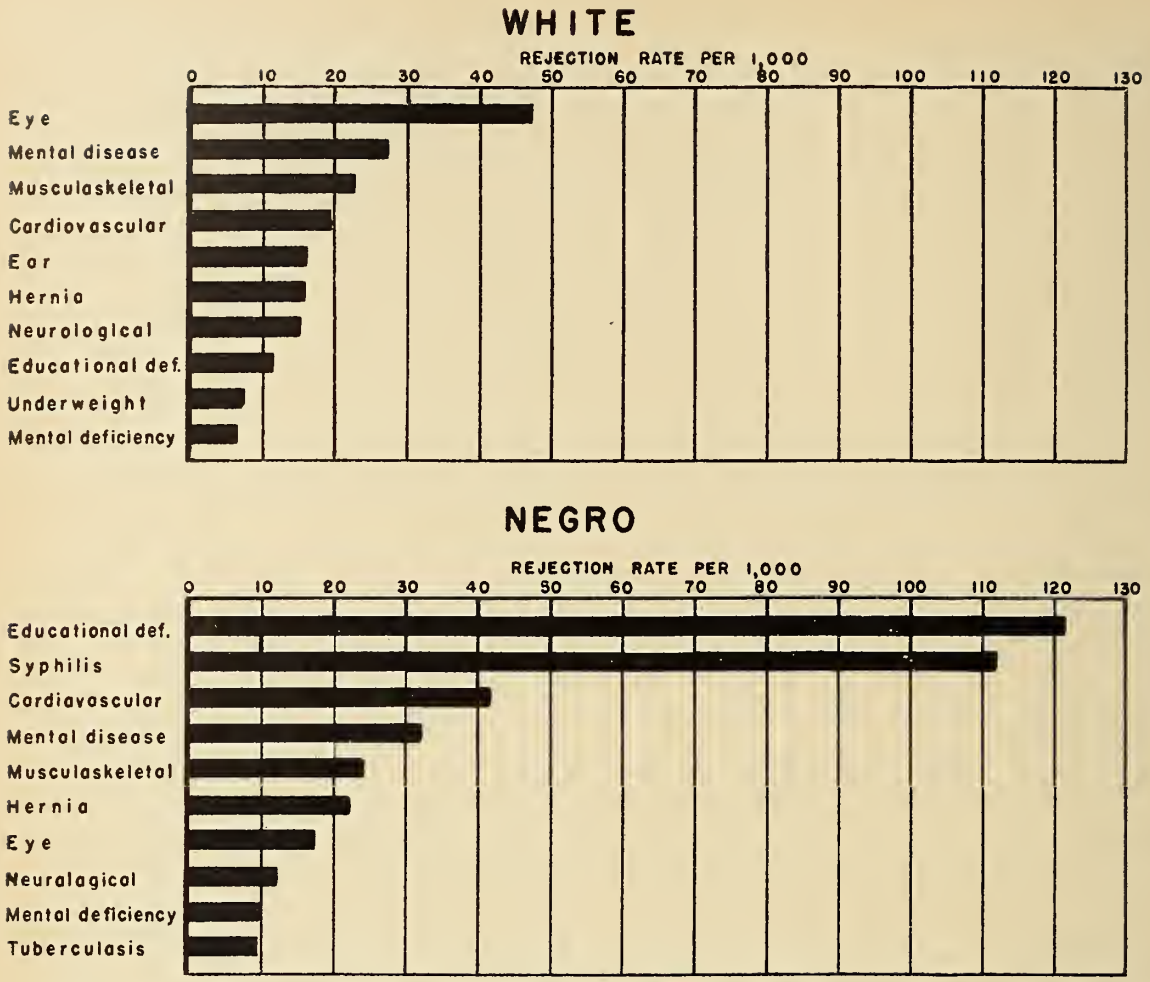


Fig. 1 *a*. Leading causes of rejections of eighteen- and nineteen-year-old registrants, by race, December, 1942–February, 1943.

Army Dental Corps, the following summary of professional services is of significant interest.*

SUMMARY OF PROFESSIONAL SERVICES OF THE ENTIRE ARMY DENTAL CORPS FOR THE YEAR 1942

Number of cases admitted for treatment	4,319,506
Number of sittings	13,009,292
Number of root fillings	8,688
Number of permanent fillings	7,830,688
Number of bridges constructed	11,405
Number of crowns constructed	6,331
Number of bridges and crowns repaired	16,685
Number of dentures constructed	145,899
Number of dentures repaired	40,527
Number of prophylactic treatments	997,447
Number of extractions	3,302,781

The Effect of Age and Rates of Rejection.—This has been made the basis of a special study and the results are depicted in tables and charts which indicate total rejections, rejections at the induction stations and at the local board levels for whites and Negroes separately, and for whites and Negroes combined.

The data cover individuals from four of the five registrations and covers also the period from September, 1942, through February, 1943. The results are based on 442,447 Reports of Physical Examination and Induction, Forms 221 received at National Headquarters.

Rejection rate appears almost as a linear function of age. Throughout the age span represented by the first registration, men born 1904 to 1919, there is a fairly close approximation to a straight line relationship between rejection rates and year of birth. This holds for local board and induction station rejection rates and for white and for Negro registrants. A linear relationship between rejection rate and year of birth has been observed

*Official release from War Department taken from the *Journal of the Michigan State Dental Society*, Volume 25, No. 8, August, 1943.

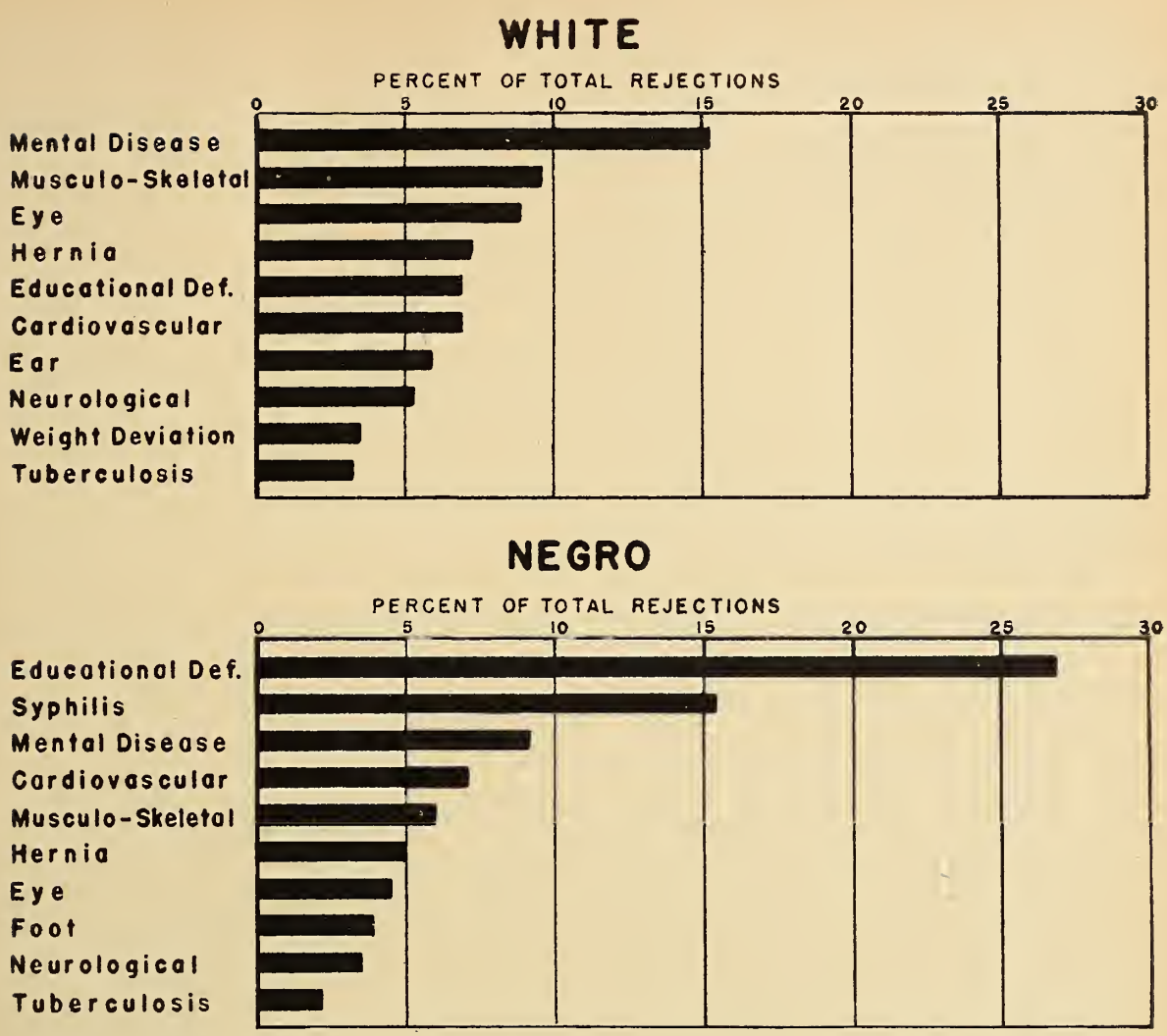


Fig. 1*b*. Leading causes of rejections of eighteen- and nineteen year-old registrants, by race, April and May, 1943.

in this registration group previously, for the period of November, 1940, through September, 1941.

Through the age span represented by the older men of the third registration, men born 1897 to 1904, the data fall almost as closely along a straight line, but not along the projected path of the plotted points of the first registration. The third registration has slightly lower rejection rates than the rates that would have been predicted by such a projection. This results from the circumstances that physically fit men have been drawn from the first registration ever since November, 1940, leaving fewer fit men behind, whereas, the third registration group was processed only from March to December, 1942. As of December 31, 1942, over 3,400,000 of the 17,000,000 in the first registration were in the armed forces, but only 325,000 of 8,000,000 in the third registration were in the armed forces. An increased rejection rate for the first registration group results, and this increase is likely to continue as long as the same dependency categories of the first registration continue to be the source of military manpower. Unfortunately the incidence of defects in relation to age is not generally available so that the only material that can be utilized at present is rejection in relation to age. From this study it would appear that the rate of rejection is essentially a linear function of age.

Causes of Rejection and the Incidence of Defects Among Eighteen- and Nineteen-year-old Selective Service Registrants.—Data on rates of

rejection, causes of rejection, and the incidence of physical and mental defects among eighteen- and nineteen-year-old registrants are here presented. This information is a sample of 45,585 Reports of Physical Examination and Induction, DSS Forms 221, received at National Headquarters of Selective Service. They represent physical examinations made at local boards and induction stations during December, 1942, and January and February, 1943.

Registrants born on or after January 1, 1922, and on or before June 30, 1924, were required to register at Selective Service local boards June 30, 1942, in the fifth registration but they did not become liable for training and service until the Selective Training and Service Act of 1940 was amended, effective November 14, 1942. Several factors limit the population under discussion here. Large numbers of physically fit eighteen and nineteen-year-old youths entered the armed forces by direct enlistment up to December 5, 1942, when induction by enlistment was discontinued. The Selective Service System was notified when registrants enlisted in the armed forces but was not advised of the physical findings of either accepted or rejected volunteers. During the period represented by these data, many youths remained in school or college under programs supported by the Army and the Navy which permitted them to finish a course of study before being called up for examination. Young men who had entered war industries or who were needed on farms and had been deferred because of occupation were not examined physically. The remaining eighteen and nineteen-year-olds whose order numbers were reached during December, 1942, and January and February, 1943, were called up for physical examination unless grounds for deferment existed and it is this group of eighteen- and nineteen-year-old registrants whose records are available for sampling and for study.

Rejection Rates

Table IV shows the local board and induction station rejection rates for white and for Negro registrants born in 1923 and 1924. Of the white youths called up for physical examination, 23.8 per cent were rejected either at local boards or at induction stations. The corresponding rejection rate for Negro youths was almost twice as high, or 45.5 per cent. The difference is attributable to the high rejection rates for syphilis and for educational deficiency among Negroes.

TABLE IV. REJECTION RATES OF EIGHTEEN- AND NINETEEN-YEAR-OLD REGISTRANTS[1]

Rejections per 100

Rejection Rate	White and Negro	White[2]	Negro
Local Board	5.2	4.3	16.5
Induction Station[3]	21.3	20.4	34.8
Combined Rate[4]	25.4	23.8	45.5

1. Based on a sample of 45,585 Reports of Physical Examination and Induction, D.S.S. Form 221, for eighteen and nineteen-year-old registrants. Registrants deferred at local board for reasons other than physical or mental defect are not included.
2. Includes all races other than Negro.
3. Based on the number of registrants who passed a local board physical examination and were forwarded to an induction station for examination.
4. Based on the number of registrants examined at local board who were rejected at local board or induction station.

Leading Causes of Rejection in Teen Age.—Figure 1 shows, by the lengths of horizontal bars, the relative importance of the ten leading causes of rejection among white and among Negro eighteen- and nineteen-year-old registrants. Later sections of this paper will discuss each of these defect groups in detail.

The most striking difference between the two racial groups concerns the high rate of rejections among Negroes for educational deficiency and for syphilis. Educational deficiency accounted for 121.7 rejections per 1,000 Negro youths examined or for 26.7 per cent for all Negro rejections. Syphilis accounted for 112.0 rejections per 1,000 or for 24.6 of all Negro rejections. The two conditions together accounted for slightly more than half of all rejections of Negro youths. Eye defects and mental disease, the leading causes of rejection among white youths, ranked seventh and fourth, respectively, among Negro youths.

Other defects appear on each of the two lists of ten leading causes of rejection but with differences among whites and Negroes. Thus, musculoskeletal defects are in third place among white youths and in fifth place among Negroes, and cardiovascular defects are fourth in importance among whites and third among Negroes. Ear defects and underweight appear on the list of ten leading causes of rejection among whites but are not important as causes of rejection among Negroes. Conversely, syphilis and tuberculosis, listed among the first ten causes of rejec-

tion for Negroes, are lower in order of importance among whites.

Similar lists are obtained by ranking the ten leading causes of rejection among registrants twenty years of age and older, as shown on DSS Forms 221 representing examinations made in the same period. Tuberculosis stands in ninth place and syphilis in tenth among whites twenty years of age and older, displacing underweight and mental deficiency. Among Negroes, tuberculosis is in ninth place and mental deficiency in tenth, reversing their order in the eighteen- to nineteen-year age group. Among older Negroes, syphilis is the leading cause of rejection, accounting for 28.7 per cent of all rejections. The other differences in rank of causes of rejection between the two age groups of each race are of minor importance.

Current Rejections in Wartime Selection as Revealed by Statistical Survey on DSS Forms 221.—Since the attack on Pearl Harbor a wartime basis for selection has obtained. The urgency of need, the numerical objective, the standards for admission and the examining procedures, all have changed materially. A program of selection for war service has developed. Selection has been extended to cover all branches of fighting forces. Enlistment no longer exists. Inductions are channeled through Selective Service. The present picture (as of April and May, 1943) varies materially from that of earlier peacetime selection.

Mental disease is now the leading cause of rejection among all registrants due to its predominance among whites. Educational deficiency ranks second because of its great predominance among Negroes and its relative frequency among whites. Musculoskeletal defects outnumber eye and visual disorders because of the lowering of visual requirements and in numbers inducted for limited service. Cardiovascular disease and hernia take fifth and sixth places; ear and neurological come next, both accounting for 5.1 per cent of the rejections; syphilis is ninth with 4.4 per cent; weight deviation tenth.

Among whites, eye defects were third in order of importance, ranking below mental diseases and musculoskeletal defects. Among Negroes, educational deficiency accounted for 27 per cent of the rejections; syphilis for more than 15 per cent and mental disease for 9 per cent; these three factors alone being responsible for more than 50 per cent of the total rejections.

VITAL STATISTICS

National Mortality and Morbidity.—The morbidity statistics reveal a good state of national health. The mortality is low and morbidity also, although this is somewhat above the level of 1942. It would appear that, despite the nation's depletion in medical men, the health of the nation continues satisfactory. The total death rate for the United States is 10.5 per 1,000—10.1 for white and 13.7 for Negro.

The Health of the Armed Forces.—The Army and Navy statistical reports indicate excellent health conditions in the camps throughout the country. These statistics deal mostly with the incidence of infectious diseases. Aside from battle casualties, deaths are infrequent and mortality uncommonly low.

In interpreting such statistics insight is necessary. Thus, for the first two years of the war, venereal disease among soldiers was at an all-time low, but during that period, no men with known venereal disease were inducted. The incidence in the armed forces was low, while the rejection rate was high. In fact, it has been plain that the contraction of venereal disease was one of the common methods of evading induction. During the last few months, registrants with venereal diseases have been inducted in increasing numbers. With the change in this policy, the venereal role is increasing pari passu with venereal admissions.

For the visualization of national morbidity the following statistics are pertinent:

1. Medical Statistical Bulletin No. 1.
2. Medical Statistical Bulletin No. 2.
3. The effect of age on rate of rejection.
4. Causes of rejection and incidence of defects among eighteen- and nineteen-year-old registrants.
5. Present rates of rejection as shown on Forms 221 for April and May, 1943.
6. Statement on mortality statistics.
7. Health of the fighting forces (any).
8. Rate of discharge for the army, as revealed by C.D.D.'s.
9. Rejectee pool of 4-F's.

DISCHARGE ON CERTIFICATE OF DISABILITY

The discharges from the armed forces due to disability now number 162,370 through April,

1943. As the fighting forces increased by leaps and bounds nationally, the number of separations also are increasing rapidly. Thus, of the 162,370 disability discharges reported through April, 13,761 were reported for January; 15,750 for February; 18,681 for March; and 20,370 for April.

While The Adjutant General's Office records do not show a breakdown of the disability discharges due to cause of disability, it is possible to estimate the number for various causes by use of a sample analysis made by the Reemployment Division of the Selective Service System. It was found that over half of the disability discharges could be attributed to one of the following causes: Psychoneurosis, ulcers, asthma, heart, arthritis, and bones and joints.

On the basis of the sample analysis of 4,714 cases, it may be estimated that the 162,370 disability discharges through April, 1943, may be distributed by cause, roughly, as follows:

Psychoneurosis	32,000
Ulcers	17,000
Asthma	11,000
Heart	10,000
Arthritis	9,000
Bones and joints	8,000
Ears	6,000
Epilepsy	4,000
Eyes	4,000
Hypertension	4,000
Tuberculosis	3,000
Amputations and injuries	2,000
Diabetes	1,000
Hernia	1,000
Undiagnosed	15,000
Miscellaneous	35,000

While the actual numbers appear quite large, relatively they are small, roughly 160,000 out of some 8,000,000 men inducted, or approximately 2 per cent.

The finding of most interest is not the total number discharged but the cause of discharge. Thus, we have 49,000 of 111,000 with specific diagnoses discharged for psychoneurosis and ulcer, the latter representing largely psychosomatic disease. At least 50 per cent of the 29,000 discharged for asthma, heart disease, and arthritis are psychosomatic in origin. It is safe, perhaps, to say that at least 50 per cent of those diagnosed are for mental and functional disease.

TABLE V. ESTIMATED PRINCIPAL CAUSES FOR REJECTION OF REGISTRANTS 18-44 YEARS OF AGE IN CLASS IV-F.
As of April 30, 1943.
(preliminary)

Principal cause for rejection	Number	Per cent	Principal cause for rejection	Number	Per cent
Total	2,870,000	100.0			
Manifestly disqualifying defects	301,400	10.5	Teeth	34,400	1.2
Educational deficiency	287,000	10.0	Abdominal viscera	31,600	1.1
Physical and Mental defects	2,270,100	79.1	Feet	31,600	1.1
Mental disease	398,900	13.9	Kidney and urinary	28,700	1.0
Syphilis	301,400	10.5	Genitalia	28,700	1.0
Musculoskeletal	209,500	7.3	Endocrine	28,700	1.0
Cardiovascular	183,700	6.4	Varicose veins	25,800	.9
Hernia	169,300	5.9	Nose	17,200	.6
Eyes	157,800	5.5	Skin	17,200	.6
Neurological	157,800	5.5	Neoplasms	17,200	.6
Ears	109,100	3.8	Gonorrhea and other venereal	14,300	.5
Mental deficiency	100,500	3.5	Hemorrhoids	11,500	.4
Tuberculosis	74,600	2.6	Mouth and gums	8,600	.3
Underweight, overweight, and other	57,400	2.0	Throat	2,900	.1
Lungs	45,900	1.6	Blood and blood forming	2,900	.1
			Infectious and parasitic	2,900	.1
			Non-medical	11,500	.4

The IV-F Pool of Rejectees.—Interest centers naturally in the pool of rejectees. This has now attained large proportions, approximately 350,000 registrants. The breakdown as of five months concerns nearly 3,000,000 and appears in Table V.

This shows mental disease in first place, 13.9, with educational deficiency and syphilis in second and third positions. Syphilis is high in this list despite the fact that limited numbers of these cases were being inducted and treated within the ranks of the military establishment. Mental disease, educational deficiency, neurological disorders, and mental deficiency account for approximately one million, or about one-third of the total number classified as IV-F.

Discussion

A study of these data permits some generalization concerning their reliability and significance and to some extent, the geographic distribution of defects, deficiencies, disorders and diseases as they exist at present throughout the nation.

1. A national picture of health and disease is emerging.—While the statistics deal entirely with males of military age, they give, at least some inkling of the health picture of the population as a whole. The picture will become more definite, however, when the statistics for women, the WAC, WAVES, SPARS, Marines, et cetera, are made public. Sufficient data are now available, however, to map the mental and physical defects of the nation with a fair degree of precision.

2. A state breakdown is highly desirable but present data are less reliable for such purpose.—Additional verification and confirmation are desirable, prior to utilizing a state breakdown of our data for the contrasting of health conditions in various states. Rates of discharges from the armed forces on C.D.D.'s must be studied in relation to rejection rates, before true significance is established.

3. Certain rough groupings of defects may be attempted at the present time on the basis of these statistics.—(a) There appears to be a "health belt" in the west, centering around the State of Colorado. Thus, Wyoming, Utah, North Dakota, Kansas, Idaho and Arizona usually have among the lowest rates for rejection. In the various surveys made at various times, certain of these states are shown to be in or out of this "health belt." A somewhat similar belt was noted during the last war.

(b) A "health defect belt" is indicated in the southeast. Rejection rates are relatively high in some of the Southeastern States: Mississippi, Arkansas, Alabama, North Carolina, South Carolina, and Florida. In these areas the ratio of Negroes is higher and this plays an important role in increasing the rejection rates.

4. Four causes of rejection are worthy of special consideration.—(a) Nervous, mental and functional diseases. These are numerous everywhere but tend to center among white registrants. (b) Educational deficiency and illiteracy. Though widely scattered, they tend to center in the Negro and in the South. (c) Venereal diseases. These are relatively infrequent in the Northern States. Venereal disease is concentrated among the Negroes in the South. (d) Dental defects. These are rife everywhere but abound most profusely in industrial centers, especially in the North and East.

These four problems, while of vast importance from the standpoint of military selection, are also of national significance from the standpoint of the civilian health. From both the military and civilian point of view the great tragedy in the situation as it exists, is that most of the defects in these categories are both preventable and curable. From the national point of view they therefore present a challenge in war and in peace to all interested in better public health.

MSMS

The Neglected Interns

By Luther R. Leader, M.D.
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The accelerated program of internships has lessened to a considerable degree the amount of training they receive. The shortening of their training period, plus the laxness of the attending men to devote time to teaching, has resulted in turning out poorly trained men due entirely to neglect. Numerous suggestions and methods of overcoming this are discussed, with the hope of the attending men fulfilling their obligations.

All members of the medical profession are well aware of the increased duties being thrust upon them by the absence of their numerous colleagues who are now serving in the armed forces; but the failure to realize the effect thrust upon the intern for the same reason appears to have gone unrecognized. We are expected to assume many additional duties and with few exceptions have fully done so, but likewise, we are not expected to shirk any duties which we in the past have considered most important to the practice and maintenance of good medicine. I speak in respect to intern training. We are duty-bound to train the younger men and because of the adoption of the "999" Plan we should be all the more conscious of the fact, and endeavor to do our

utmost for the younger men whose intern training has been cut to nine months, instead of twelve.

Members of most hospital staffs expect much of their interns, and with reason, for they are usually dealing with capable, intelligent young men who are eager to make the most of their opportunities during the all-important year of internship. And, conversely, the intern expects much from his chief.

The usual, and often perfunctory word of advice on ward rounds, in the operating room, in the clinic, or in the dispensary is not enough. A carefully-organized and comprehensive teaching plan is essential. The desire to impart helpful instruction should mark the members of the major staff, aware as they are of the fact that the fifth year is also a year of instruction—a practical continuation of the four years in medical school. They should appreciate therefore that a very real responsibility rests upon them to make sure that a carefully-planned, very comprehensive, and generally helpful program of laboratory, operating room, and bedside instruction is planned and carried out.

The intern should be encouraged to present before suitable meetings, either abstracts of case histories or abstracts which are taken from significant current literature. The intern should be instructed to select a major subject in which he is particularly interested, concerning which he should seek helpful suggestions, with the idea of making it a special problem of study. To this subject the intern should devote the greater part of his spare time, having as his object the presentation of a carefully-prepared essay, one which is suitable for publication. Interns fail in these matters in proportion, as their chiefs fail in providing proper opportunity and encouragement.

One of our most important functions is that of providing our interns with as interesting and valuable service as is humanly possible.

Practical Assistance

The members of our staffs should unanimously agree that no part of their professional work gives them greater pleasure than the opportunity to help the younger men, and that nothing affords them greater satisfaction than the chance to be of practical assistance to the interns at a time when a little well-directed guidance may serve to deflect them from the pathway of the routine worker into a career of great scientific productiveness and professional success.

Many a brilliant career began in the hospital during the intern period, largely the result of the friendly guidance of an older man. Many a potentially capable and productive man has found himself drifting into a life of hopeless mediocrity, due chiefly to the lack of proper help and direction at the period of his career when they were most needed. Many a great figure in our profession accredits the beginning of his way upward to the hospital internship when, as a young man, he came under the guidance of a strong personality.

Too often, hospital staff members are so far removed from their own student days that they fail to recall the intern's problems, or they are so deeply concerned with their own personal affairs that they lose true perspective of the problems which face the intern.

Even those hospital executives who feel that they are giving the intern every assistance would be surprised could they read the thoughts of the average intern. Here frank discussion of the service and helpful criticisms and constructive suggestions are solicited. I believe that if this practice were followed, the intern's service would be improved, the service to both the hospital and patient would be raised to a higher level, and the aid rendered to the chiefs themselves would be more efficient.

Intern Responsibilities

The interns are of the opinion that their work is not checked sufficiently; that they are given responsibilities which they are incapable of assuming without proper guidance; that there is not enough time spent on bedside instruction. They complain that while they are often informed that they are wrong, they are rarely told why; that the rationale of diagnosis and treatment is not explained, and that they are in the hospital not only to serve but also to learn, and that learning comes very largely through teaching. It is a common complaint among interns that when they are right and are performing especially meritorious work, they are seldom commended.

Interns confess to having a constant desire for more explanation on the part of the clinician and less routine; they feel that the operations are hurried through, while at the end of the retractor, the interns hunger for demonstration of what is being done and why, so that the time which they spend in assisting will be profitable. They

feel that they should have more instruction in the conduct of pelvic examinations, in carrying out minor surgical procedures, in the handling of fractures, and in the performance of minor dispensary operations. They feel that they should be given a greater opportunity for presenting case reports and other papers; followed by constructive criticism and analysis on the part of their more experienced listeners.

Programs of Instruction

Frequently interns remark that during the intern year there is no definite program of instruction; that as a result they become nothing but history writers, drudges tolerated as a necessary evil, mere clerks or dressers; that the chiefs should realize that an ambitious and capable intern who tries to get along as best he can, could be helped tremendously by skilled and sympathetic guidance. They ask for greater opportunities to take part in staff conferences; for closer contacts with the staff members, socially as well as professionally.

One prominent defect in our present system of hospital training of interns is allied with that phase which tends to encourage immediate specialization; a system which sends young men into restricted fields before they have had sufficient experience with the fundamental branches of medicine. Fortunate is the intern who secures one or two years of general rotating service, covering the major branches of medicine, especially pathology. In this way he receives a bird's eye view of the entire science before he takes up an intensive course of study in one of the specialties. If he has had such an opportunity, at the outset his viewpoint is greatly broadened, and early in his career he develops a wholesome taste for research and investigation. Every intern should be given an opportunity at the earliest moment to think logically and to correlate practically his applied knowledge, a result which would be assured by a close intellectual felowship between the senior staff members and their interns.

Hospital executives fall far short of the fulfillment of a clearly-defined obligation if they fail to make every effort to facilitate and to improve the work of the younger men who are placed under their direction. Furthermore, it seems to be the duty of the professional staff to be constantly on the alert to discover the superior men in the group, and to furnish them with opportunities to perfect themselves in the fields for which they show aptitude.

These, then, are some of the things we as hospital executives, administrators, trustees, and staff members should constantly bear in mind in our hospital relationship during the young doctor's internship.

MSMS

Analysis of Deaths Occurring in Michigan from Pneumonia (All Forms)

By A. B. Mitchell, M.D., M.P.H.

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A reclassification of deaths attributed to pneumonia occurring in the age group 5-49 years was made during the winter of 1941-1942. The reclassification was based on confidential information not appearing on the death certificates but obtained directly from the physicians or coroners who reported the deaths. On the basis of this more complete information, a considerable error is found in the reporting of deaths as pneumonia. This error is attributable to incomplete or improperly recorded data on the death certificates.

As part of the pneumonia program of the Michigan Department of Health, a study was made of deaths recorded as resulting from pneumonia during the period November 1, 1941, to April 30, 1942, in the age group five to forty-nine years. The purpose of this study was to determine what factors other than pneumonia contributed to the pneumonia mortality, and the relative importance of these factors and the pneumonia to the ultimate outcome. The study was sponsored by the Michigan State Medical Society and carried out with the coöperation of physicians of the state reporting deaths in this age group.

Two hundred sixty-two deaths in the age group five to forty-nine years were classified as pneu-

TABLE I. RECLASSIFICATION OF PNEUMONIA DEATHS (PNEUMONIA—ALL FORMS)
On Basis of Additional Information Received from Physicians in Charge of Case

Classification	Deaths	Per Cent of Total
Overwhelming pneumonia	77	34.5
Secondary pneumonia	59	26.5
Terminal pneumonia	35	15.7
Not pneumonia	17	7.6
Cause of death unknown	8	3.6
Incomplete information	27	12.1
Total	223	100.0

monia deaths by the Bureau of Records and Statistics during the period studied. This classification was made from information appearing on the death certificates, according to the established procedure outlined in the Manual of the International List of Causes of Death and Joint Causes of Death. For each such death reported, the physician who signed the death certificate was requested to submit a confidential clinical report giving all data pertinent to the case. In many instances further information was obtained by personally visiting the physician or reviewing the hospital record of the patient.

In all, 223 deaths were reviewed and reclassified on the basis of all available information into the following six categories:

Overwhelming pneumonia—those cases in which the pneumonia appeared to be primarily responsible for the outcome.

Secondary pneumonia—those cases in which the pneumonia appeared as a complication of some other chronic debilitating condition or severe acute illness.

Terminal pneumonia—those cases in which the pneumonia was a purely terminal phenomenon occurring in the course of some other more serious illness.

Not pneumonia—those cases in which there was no evidence to support a diagnosis of pneumonia.

Cause of death unknown—those cases in which the cause of death was never established.

Incomplete information—those cases for which insufficient information was available to justify classification under any of the above headings.

Table I shows the breakdown of the 223 deaths classified according to the above outline. Seventy-seven, or 34.5 per cent of these deaths, were due primarily or wholly to the pneumonia. Another fifty-nine deaths, or 26.5 per cent of the total, were secondary pneumonias complicating other serious or prolonged illnesses. In this group are included seventeen chronic alcoholics, for the most part alcoholics with delirium tremens. Pneumonias in chronic alcoholics have been included here because alcoholism is itself a serious chronic debilitating condition and a predisposing factor to pneumonia and other intercurrent infections. With some of these cases, I believe it would have been perfectly proper to have considered the alcoholism as the cause of death, and the pneumonia a terminal pneumonia.

Thirty-five deaths, or 15.7 per cent of the total, were due primarily to some condition other than the pneumonia, the pneumonia appearing as a purely terminal phenomenon. In several instances the pneumonia was not diagnosed clinically but found at autopsy. None of these deaths should have been attributed to the pneumonia. There are two apparent reasons for their having been so classified. In many instances the physician neglected to designate the pneumonia as terminal on the death certificate. In others the terms terminal lobar and terminal bronchopneumonia were used, which are classified in the International List of Causes of Death as lobar and bronchopneumonia, respectively. This classification gave them precedence over the true cause of death. Only the term "terminal pneumonia" without other pathological designation, is acceptable for terminal pneumonias.

Seventeen deaths, or 7.6 per cent of the total, were definitely not pneumonia deaths. Most of these appear here because at the time the death certificates were made out the diagnosis had not been definitely established, and no subsequent corrections were made.* Four of the seventeen deaths were reported as virus pneumonias for

*Alterations of death certificates can be made only on written request of the one who signed the certificate.

TABLE II. CONDITIONS ASSOCIATED WITH DEATHS
Classified from the Death Certificates as due to Pneumonia

Associated Conditions	Number of Times Recorded	Per Cent of Total Cases
Mental	30	17.5
Heart and coronary disease	26	15.2
Chronic alcoholism	17	9.9
Purulent infections	7	4.1
Cripple	5	2.9
Operation	2	1.2
Other serious illness	30	17.5
None	66	38.6
Total	183 (171 cases)	——

which there is at present no satisfactory classification. Most of the remaining deaths were deaths from influenza with pulmonary complications, a separate classification, no mention of influenza having been made on the death certificate.

The cause of death was never established in eight cases, either before or after death. Two of these were coroners' cases, the diagnosis being based on information obtained from relatives.

Sufficient information for satisfactory classification was not obtainable for twenty-seven cases. Among these are most of the coroners' cases in which the diagnoses were based on incomplete autopsies. There was a total of twenty-eight coroners' cases in the series.

Table II lists the conditions associated with pneumonia in the 171 deaths classified as overwhelming, secondary, and terminal pneumonias. Mental conditions of sufficient degree to affect the outcome were recorded in thirty cases, or 17.5 per cent of the total number of cases. In fourteen of these the pneumonia was classified as secondary and in sixteen as terminal pneumonia. Preexisting heart and coronary diseases were recorded as associated conditions in twenty-six cases, or 15.2 per cent. In eighteen of these the pneumonia was classified as secondary, in six terminal, and in two overwhelming pneumonia. In the latter two cases, the physicians did not feel that the heart conditions materially influenced the outcome. There were seventeen cases suffering from chronic alcoholism. In all of these, the pneumonia, as previously stated, was classified as a secondary pneumonia.

Purulent infections were the cause of death in seven cases, the pneumonia being a purely terminal phenomenon. In several of these cases the pneumonia was found only at autopsy. Crippling conditions of such a nature as would predispose one to pneumonia were recorded in five cases. In three of these, the pneumonia was classified as an overwhelming pneumonia and in the other two as a secondary pneumonia.

Other illnesses of one kind or another were recorded as associated conditions in thirty cases. In eight of these the other illness was considered the determining factor rather than the pneumonia and the pneumonia classified as terminal. In fifteen cases the pneumonia was classified as a secondary pneumonia and in seven it was felt that the pneumonia itself was the deciding factor and the pneumonia classified as an overwhelming pneumonia.

Conclusions

A study of joint causes has been made of 223 of the 262 deaths from pneumonia occurring in Michigan during the period November 1, 1941, to April 30, 1942, in the age group five to forty-nine years.

Pneumonia either as an overwhelming infection or secondary to some other serious illness was responsible for only 61 per cent of the deaths recorded in this age group as pneumonia.

Twenty-six and nine-tenths per cent of the deaths recorded as pneumonia would not have been so classified had the causes of death been properly stated on the death certificates.

The only factor other than incomplete or improperly completed death certificates brought out in this study is that of other preëxisting serious disease, the principal ones being mental disease, heart and coronary diseases and chronic alcoholism.

MSMS

Although these men were fully aware of the danger of contracting scrub typhus, they voluntarily applied themselves to the task of preparing camp sites in order to bring about the rapid and complete control of this disease on Goodenough Isalnd. Their services were rendered during the periods of December 27, 1943 to February 7, 1944, and March 13-22, 1944.—U. S. Army report.

EDITORIAL

1944 POSTGRADUATE CONFERENCE ON WAR MEDICINE

■ The Seventy-ninth Annual Session of the Michigan State Medical Society which will convene in Grand Rapids, September 27, 28 and 29, will be the fourth War Conference. It will be the equal of all previous ones, and we believe will be better than any that have gone before.

The program is published in this number of The Journal. Committee reports, and all material available for the meetings of the House of Delegates and the Council, have been presented. The Council and the House of Delegates will have been in session a day or two before the General Meetings, and will have disposed of the vast amount of business that makes up the administration of a great medical society.

The Discussion Conferences with the guest essayists in attendance which were such a success the past three years are again a feature, each day at 4:00 to 5:00 p.m. This is your opportunity to discuss with an expert the problems that are puzzling you.

Your busy practice has been your lifesaving blessing during these trying times and has provided an outlet that has been a boon to your patients, but you owe it to them and to yourself to attend this Conference. You will bring back far more than just a restful recuperation—you will come home inspired to carry on.

It is not too late to plan on attending this meeting. Make hotel reservations NOW.

ANDREW P. BIDDLE

■ Andrew P. Biddle, M.D., is dead. Everybody knew Andrew Biddle. He was a medical institution in Michigan. Trained for the Navy, he was a strict disciplinarian, not only of his followers and associates, but of himself. Doctor Biddle was a Major in the Spanish war, and diagnosed the typhoid epidemic which was the great scourge of that war.

In 1902 Doctor Biddle was of that group of far-seeing men who re-organized the Michigan State Medical Society and established this Journal. He was the first secretary and the first editor of one of the earliest state medical journals. So well did he discharge his new and unprecedented duties that he became the most beloved leader of his profession.

He served as secretary-editor only four years, during the last two of which the present editor was a student in his office. He was President of the Michigan State Medical Society at the outbreak of the first World War, and was re-elected to succeed himself, the only case in our history.

He has always been keenly interested in Postgraduate Medical Education.

We who loved him and those who knew and admired him will profoundly miss him.

Wilfrid Haughey

THE SERVICEMEN'S READJUSTMENT ACT OF 1944

■ The "G.I. Bill of Rights" became law on June 22, 1944, as U. S. Public Law 346, and every doctor in the country is interested. Benefits available to servicemen are manifold.

Title I deals generally with hospitalization, claims and procedures, aid by veterans' organizations, and the review of discharges or dismissals from the armed forces. It provides an appropriation of $500,000,000 for construction of new hospital facilities for veterans as well as providing for existing hospitals; it also provides for the transfer of commissioned or other personnel from the armed forces to the Veterans' Administration for periods not exceeding six months after the termination of the war; and it provides adequate training in the use of prosthetic appliances. Hospitalization of the veteran is pretty well attended to. We are unable to find any time limitation for the expiration of the rights to hospitalization, except for those who have been separated from the service for disability in which case the application shall be filed before fifteen years from the date of this act or the termination from the service whichever is later. There are several doctors in Michigan already eligible under this title of the Act.

Title II is of most importance. "Any person

(Continued on Page 784)

Medicine Fares Forward

The war has done a good many things to us as members of the Michigan State Medical Society. For one thing it has changed thousands of us, who used to be mere spectators, into participants in the social and economic life of this state. We have become conscious that we have no right to sit idly by and allow politicians to do our thinking for us.

These are not ordinary times. To play our part and take advantage of such victory as we have attained, such headway as we have made, we shall have to alter our conception of our profession to include and stress the economic phase of medicine.

A vigorous program of attack is the only approach that has any chance of success over concerted action to bring about the stark reality of controlled medicine. Doctors should come of age in economics. It is to be hoped that this program will also include still more constructive steps in the long march toward a united front in meeting the common medical needs of this sovereign State of Michigan.

For a year, I have enjoyed the highest honor which the Michigan State Medical Society can bestow, the presidency of this organization. I have watched with great interest the growth of united solidarity in our profession. I have been deeply impressed by the willingness and sincerity of fellow workers who shouldered responsibility and gave me competent aid in the administration of this Society. I shall never cease to be profoundly grateful for the distinct values which have accrued to me through this generous and loyal association.

We should expect real achievement in the future. Andrew S. Brunk, M.D., succeeding me, will launch an especially progressive program for the coming year. Your continued alert support should greatly assist your president in his effort to continue an uncontrolled medicine. Dr. Brunk will be capable of handling the affairs of this Society during the crucial days ahead. He has the strength of his convictions, integrity and the courage to lead us to the ultimate fulfillment of the fundamental ideals incorporated in the principles of this Society.

As we look over this year's accomplishment, we can discern some trails being gradually blazed through the underbrush of crowded events. We see a recurring attempt to bring order out of confused planning, to substitute voluntary adjustment of medical need for resort to controlled medicine. Our watchword has been well expressed by the poet, T. S. Eliot, when, in a greeting to mariners, he said, "Not farewell, but fare forward, voyagers!"

C. R. Keyport

President, Michigan State Medical Society

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President's



Page

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who served in the active military or naval service on or after September 16, 1940, and prior to the termination of the present war, with an honorable discharge, and whose education or training was impeded, delayed, interrupted, or interfered with, by reason of his entrance into the service, or who desires a refresher or retraining course, and who shall have served ninety days . . . shall be eligible for and entitled to receive education or training under this part." The application for training must be made within two years and the training must not extend over seven years after the termination of the war.

Under this title any doctor in the service may have a refresher or retraining course up to one year, and that could include any studies the doctor might pursue, just so they are medical studies. Any younger doctor whose training for a specialty, for instance, was interrupted by entrance into the armed forces, and he can establish this fact (which is presumed if he is not over twenty-five), can continue his studies for a period of one year plus additional period or periods of education or training, not to exceed the time such person was in the active service on and after September 16, 1940, and before the termination of the present war, exclusive of any period he was assigned for a course of education or training in his own line under army or navy specialized training; but in no event shall this training exceed four years.

This gives younger men a chance to take training up to a full medical course for one who has completed premedical training. Tuition, laboratory, health, infirmary, and other similar fees customarily charged up to $500 per ordinary school year will be paid and it may include books, supplies, equipment, and other necessary expenses, exclusive of board, lodging, other living expenses and travel. Also allowed while pursuing this education is $50 per month if without dependents or $75 if he has dependents. There is an allowance of thirty days holidays or leave in any calendar year.

Title III provides for a loan 50 per cent of which is guaranteed by the Administrator, provided that the aggregate amount guaranteed shall not exceed $2,000. This may be used to purchase, rebuild, or construct on property owned by the veteran, and to be used by him for a residence. A guarantee loan to the same amount and under similar terms "may be used for the purchase of any business or personal property to be used by him in the bonafied pursuit of such gainful occupation." This could provide an office building and equipment, for any medical veteran. Under certain circumstances a second loan may be made up to $2,000, all guaranteed. Applications for these loans must be made within two years after the termination of the war, or service, whichever is later, but not later than five years after the war.

CONTINUING MEDICAL EDUCATION

■ THE die has been cast. The flow of premedical students has been stopped. As of July 1, 1944, all students not already enrolled in medical classes are subject to induction in the army, and will not be sent to premedical training, as had been proposed by the armed forces when they took over practically eighty per cent of the medical college facilities. That program was canceled last April. Protest was made; The House of Delegates of the American Medical Association adopted resolutions, but the Selective Service authorities decided these young men were of "more use to the armed forces now than their potential use as doctors of medicine in 1949."

This situation has been foreseen: In December, 1942,* we asked editorially: "How will we recruit the ranks and keep an even number of new graduates flowing into the practice of medicine to replace losses by death and retirement, with the collegiate young men of eighteen to twenty being subject to the draft, and no exemptions provided for prospective medical students?"

For some years we think we have seen a tendency for bureaucracy to attempt to gain control over the field of medicine. Can this present stoppage of the training of doctors be another step? Our appeals for the deferment of premedical students have been denied, and at last the President has closed the case by refusing to interfere. Under the present law it seems impossible to defer premedical students, for the benefit of the health of the nation, and to correct this situation Congressman Louis E. Miller of Missouri (a doctor of medicine) introduced H.R. 5128 to provide that Selective Service shall defer not less than 6,000 medical students and 4,000 dental students each year.

If we remember correctly that action was not

*(Jour. M.S.M.S. December, 1942, page 1064.)

necessary early in the war for General Hershey to advise the deferment of osteopaths, and later osteopathic students. If one can be deferred the other can, even under our present laws.

However, to correct a stoppage in medical education that has already been put into effect YOU, Doctor, must urge your congressmen to support H.R. 5128.

HISTORY REPEATS

■ "SHOCKING Reports on Health in the U. S. Given to Senators." Such is the heading of an article sounding strangely familiar. A few years ago there was a sustained build-up leading to demands on the medical profession, and threats that the health of the people was poor, that 40 per cent were unable to get adequate medical care, and then a spew of bills and suggestions looking toward the taking over of medicine, ending in the first Wagner bill.

We all flew to defense; there was a special session of the A.M.A. House of Delegates; there was an attempt by government bureaus to enter the practice of medicine through co-operative medical service plans of a closed sort; then the indictment of the American Medical Association et al., and a Supreme Court decision which in effect takes away the right of an individual to choose his own doctor. The ground being thus prepared, the Murray-Wagner-Dingell bill emerged to what looked like clear sailing.

There were delays. The course of socializing of medicine was not so smooth. Legislative action slowed up. It is now time for another attack on medicine and here it is. The health of the youth of the country is rotten. Selective Service is finding one-third of the young people examined for the draft unfit for service. *"Medical experts are agreed that there is urgent necessity for concerted effort to use the information and experience of Selective Service to prepare a national program of Health."**

The first mentioned and quoted of the "medical experts" before the sub-committee were Maj. Gen. Lewis B. Hershey, Director of Selective Service, who protested against "a situation in which the older men must be called to service by the fact that so many of the young men are physically or morally deficient." The second witness, Paul V. McNutt, WMC Chairman deplored the necessity of drafting pre-medical students but has done nothing about it.

Chairman Claude Pepper of the senate sub-committee said:

"As a nation at war, we have learned a profound lesson about the effects of sickness and physical and mental defects. This lesson has been driven home to us by the alarming fact that more than four million young men have been found ineligible for military service—a discovery which has removed any false complacency we have had about the nation's health."

Is it not a perfect setup for a further drive for national compulsory Health Service?

THIS TIME A RAY OF UNDERSTANDING

■ A staff reporter for the *Detroit Free Press*, Arthur Juntunen, refutes the charge of unfitness for Michigan young men. Self-indulgence gets the blame. It is an indictment of the American people and of our way of life. The Editor of the *Free Press* has this to say, and he has ably written our editorial for us:

ARE WE FLABBY?

Nothing is more vital to a nation than the health of its people. Therefore, the hearings now going on in Washington before the Senate Committee on Wartime Health and Education may be of tremendous importance. The hearings at least afford a sounding board for those in responsible positions to reveal what the physical and mental condition of our democracy may be.

Such men as Paul V. McNutt, WMC chairman; Maj. Gen. Lewis B. Hershey, director of Selective Service, and Army and Navy medical authorities have testified that the state of our national health is "appalling." It was agreed that one-third of the men examined for service proved mentally or physically unfit for fighting.

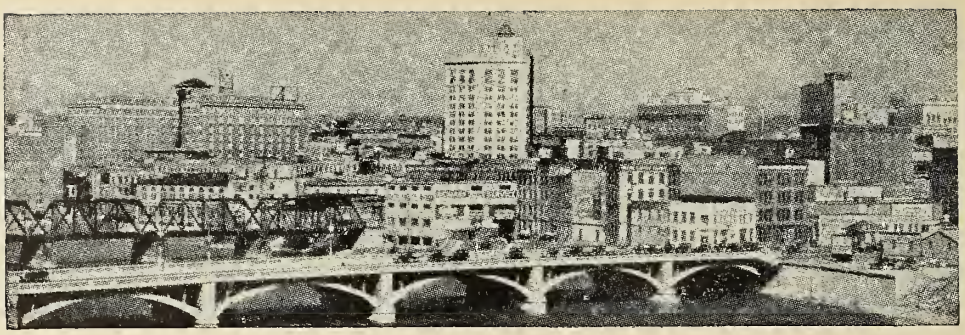
"We found American youth soft and flabby," declared Col. Leonard Rowntree, medical director of Selective Service.

The purpose of any hearing by a senate committee is to gather information for consideration of legislation. We are not in position to know what health legislation Senator Claude Pepper and his committee have in mind.

The testimony thus far given is startling and should bring forth an immediate and nation-wide response. But it is not conclusive because it offers no comparisons. In the first World War we were horrified to learn from

(Continued on Page 814)

*Reports of Pepper sub-committee hearings.



Grand Rapids Skyline

GRAND RAPIDS, CONVENTION CITY

■ You'll like Grand Rapids because it has just everything for your pleasure, your comfort, your health and your profit. Whatever your interests, Grand Rapids affords fullest advantages. Here are all forms of recreation, large volume business, central location and convenient transportation facilities in every direction.

Founded as an Indian trading post by "Uncle" Louis Campau in 1826, Grand Rapids has grown steadily in population, in industrial and commercial importance and cultural significance.

Scenic hills, quiet streams, shaded streets form the jeweled setting in which live a happy, energetic, prosperous people. Rich in natural resources, Grand Rapids is also possessed of a superb climate, where cool breezes soothe and invigorate the heat-weary, out-state visitor in summer. Winters are moderate and stimulating.

With a contiguous area exceeding 250,000 population and a wholesale trading area of 1,552,646, Grand Rapids is truly metropolitan in all respects, with major facilities of commerce, industry, government, schools, churches, hospitals, public utilities, city transit, intercity transport, highways, airways, parks, amusement centers and residential areas.

Second city of the nation's leading industrial state, Grand Rapids is but 85 miles from the Indiana state line, 170 miles from Chicago, 150 miles from Canada at Detroit, 30 miles from Lake Michigan. Four major railroads, 21 common motor carriers and 20 airplane passenger transport flights a day in all directions in peacetime assure quick connections with major markets.

Any of the 250 lakes and trout streams for fishing, boating and rest can be reached within an hour from Grand Rapids. Ten minutes drive will take you to one or more of eleven sporty golf courses, where hospitality is the basic rule. Bathing beaches and pools, tennis and



Butterworth Hospital

badminton courts, skating rinks and dance pavilions, theaters, baseball parks and recreation centers afford superb amusement.

Grand Rapids is constant and even-keeled economically. Employment is stable. Coöperation is the keynote of industrial relations. Hydro-electric power, natural gas and Lake Michigan filtered water, furnish low-cost utilities. An efficient commission-manager municipal government rules. A charter provision limits taxation. Health and education standards are high. Churches flourish.

Ample, air-conditioned convention facilities, hotels, auditoriums and exposition halls, restaurants and refreshment establishments attract scores of conventioning groups, recalling them year after year.

Grand Rapids normally boasts an unusual diversification of industry and with practically all of her plants engaged in war production and greatly expanded, this diversification has been greatly augmented.

THE 79TH ANNUAL SESSION

1944 POSTGRADUATE CONFERENCE ON WAR MEDICINE

GRAND RAPIDS



C. R. KEYPORT, M.D.
Grayling
President



V. M. MOORE, M.D.
Grand Rapids
Chairman of Council



P. L. LEDWIDGE, M.D.
Detroit
Speaker, House of Delegates

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Grand Rapids, Michigan, on September 25, 26, 27, 28, and 29, 1944. The provisions of the Constitution and By-laws and the Official Program will govern the deliberations.

C. R. KEYPORT, M.D.
President

V. M. MOORE, M.D.
Council Chairman

P. L. LEDWIDGE, M.D.
Speaker

E. A. OAKES, M.D.
Vice Speaker

Attest:
L. FERNALD FOSTER, M.D.
Secretary



L. FERNALD FOSTER, M.D.
Bay City
Secretary



W. A. HYLAND, M.D.
Grand Rapids
Treasurer



A. S. BRUNK, M.D.
Detroit
President-Elect

ANNUAL SESSION INFORMATION

DIRECTORY

Headquarters and Registration....Civic Auditorium
Telephones: 9-6266, 9-1145, 9-1977
Hotel Headquarters.....Pantlind Hotel
Telephone: 9-7201
Scientific and Technical Exhibits..Civic Auditorium
General Assemblies, Black and Silver Ballroom, Civic Auditorium
Telephones: 9-1813, 9-1983, 9-1313
Publicity, Press Room, Room A..Civic Auditorium
Telephone: 9-6266
MSMS Hospitality Booth, Exhibit Floor Civic Auditorium
Woman's Auxiliary, Headquarters and Registration.....Pantlind Hotel

* * *

MEETING ROOM DIRECTORY

Pantlind Hotel

Ballroom—West of lobby—up grand staircase
Grill Room—Northwest corner (next to the Pub)
Schubert Room—Southwest corner of hotel. Use corridor from lobby.
Michigan Room—Mezzanine floor, behind elevator.
Mezzanine Lounge—Mezzanine floor, directly east of elevators.
Amber Suite—Second floor, left of elevators.
Parlor A-B—Mezzanine floor, directly east of elevators.

Civic Auditorium

Black and Silver Ballroom—West side of building *(through exhibits)*
Rooms B-C-D—East side of building, to right of entrance
Room F—South of Black and Silver Ballroom, off lobby *(through exhibits)*
Room G—Above Room F *(through exhibits)*
Red Room—Southwest corner, *second floor,* next to Room F *(through exhibits)*

* * *

Register—Exhibit Floor, Civic Auditorium, Grand Rapids—as soon as you arrive.

Hours of Registration daily 8:30 a.m. to 5:30 p.m. on Tuesday, Wednesday and Thursday, September 26-27-28, and from 8:30 a.m. to 2:30 p.m. on Friday, September 29.

Admission by badge only, to all scientific assemblies and section meetings. Monitor at entrance.

BRING YOUR MSMS OR AMA MEMBERSHIP CARD TO EXPEDITE REGISTRATION.

No registration fee to members of the Michigan State Medical Society.

* * *

Michigan Physicians, not members, if listed in the American Medical Directory, may register as guests upon payment of $5.00. This amount will be credited to them as dues in the Michigan State Medical Society FOR THE BALANCE OF 1944 ONLY, provided, they subsequently are accepted as members by their County Medical Society.

* * *

Wm. A. Hyland, M.D., Metz Building, Grand Rapids, is General Chairman of the G. R. Committee on Arrangements for the 1944 MSMS Annual Session.

* * *

THE 118 EXHIBITS WILL REMAIN OPEN FOR YOUR INSPECTION UNTIL 6.00 P.M. ON WEDNESDAY AND THURSDAY; AND UNTIL 2:00 P.M. ON FRIDAY

PAPERS WILL BEGIN AND END ON TIME

Believing there is nothing which makes a scientific meeting more attractive than by-the-clock promptness and regularity, all meetings will open exactly on time, all speakers will be required to begin their papers exactly on time, and to close exactly on time, in accordance with the schedule in the program. All who attend the meeting, therefore, are requested to assist in attaining this end by noting the schedule carefully and being in attendance accordingly. Any member who arrives five minutes late to hear any particular paper will miss exactly five minutes of that paper!

"Ubiquitous Hosts"—Doctors of Medicine who place themselves generally at the disposal of the 28 guest essayists who are on the Program of the MSMS Postgraduate Conference on War Medicine, have been selected for the 79th Annual Session in Grand Rapids. These physicians, who will demonstrate what Michigan hospitality means, include Wm. A. Hyland, M.D., B. R. Corbus, M.D., J. W. Logie, M.D., Marshall O. Alexander, M.D., Merrill Wells, M.D., A.B. Thompson, Jr., M.D., Frank Doran, M.D., L. W. Faust, M.D., R G. Laird, M.D., Paul Willits, M.D., Willis Dixon, M.D., John T. Hodgen, M.D., William Vis, M.D., Robert H. Denham, M.D., J. B. Whinery, M.D., Fred P. Currier, M.D., L. J. Schermerhorn, M.D., Norman S. Vann, M.D., Lynn Ferguson, M.D., L. C. Bosch, M.D., Clarence H. Snyder, M.D., A. Ray Hufford, M.D., all of Grand Rapids, and Ray S. Morrish, M.D., of Flint.

Sincere thanks are extended these hosts for their tangible help in making the MSMS Annual Session an outstanding success.

* * *

Guests—Members of the American Medical Association from any state, or from a province of Canada, and physicians of the Army, Navy and U. S. Public Health Service are invited to attend, as guests. No registration fee. Please present credentials at Registration Desk.

Bona fide doctors of medicine serving as interns, residents, or who are associate or probationary members of county medical societies, if vouched for by an MSMS Councilor or the president or secretary of the county medical society, will be registered as guests. Please present credentials at Registration Desk.

* * *

Telephone Service—Local and Long Distance telephones will be available at entrance to Black and Silver Ballroom in the Civic Auditorium, as well as in the Pantlind Hotel.

In case of emergency, doctors will be paged from the meetings by announcement on the screen.

During meetings call 9-1813, 9-1983, 9-1313.

At other hours, call the Pantlind Hotel, 9-7201, or the Registration Desk in the Exhibit Hall, Civic Auditorium, 9-1145 or 9-1977.

* * *

Checkrooms are available in the Pantlind Hotel, and in the lobby of the Exhibit Hall, Civic Auditorium.

Public Meeting—The evening assembly of Wednesday, September 27—Officers' Night—will be open to the public. Invite your patients and other friends to this interesting meeting. The program (complete on page 796) is highlighted by:

8:30 p.m. President's Address
Induction of President-elect
9:30 p.m. Biddle Oration (Preston Bradley, D.D., LL.D.)

* * *

State Society Night—Thursday, September 28, 1944, 8:30 p.m., Ballroom, Pantlind Hotel, Grand Rapids. **(Admission by card.)**

8:30 p.m.—Report on Survey of Michigan Medicine.
9:15 p.m.—General Discussion.
10:00 p.m.—Adjourn to Supper Club Room.

* * *

Guest Essayists are very respectfully requested not to change time of their lecture with another speaker without the approval of the General Assembly. This request is made in order to avoid confusion and disappointment on the part of some members of the audience.

* * *

Acknowledgment—The Michigan State Medical Society sincerely thanks the Michigan Tuberculosis Association for its sponsorship of the lecture presented by Herman E. Hilleboe, M.D., Bethesda, Md.

* * *

Scientific and Technical Exhibits—118 displays—will open daily at 8:30 a.m. and close at 6:00 p.m. with the exception of Friday when the Exhibits will close at 2:00 p.m. Frequent intermissions to view the exhibits have been arranged before and after the General Assemblies and Section Meetings.

PLEASE REGISTER AT EACH BOOTH

* * *

Postgraduate Credits are given to every member who attends the Postgraduate Conference on War Medicine, the annual session of the Michigan State Medical Society, Wednesday, Thursday, Friday, September 27-28-29, at Grand Rapids.

* * *

Press Relations Committee—Torrance Reed, M.D., Chairman, and W. B. Mitchell, M.D., of Grand Rapids.

* * *

Parking—Do not park your car on the street. Convention parking near the Civic Auditorium will be marked off with suitable sidewalk signs. The Grand Rapids Police Department will issue courtesy cards (at Registration Desk) for out-of-town autos, which give parking privileges but do not apply to metered spaces. Near-by parking lots are available, as well as convenient indoor parking facilities. The indoor parking rate at the Pantlind Garage is 75 cents for twenty-four hours. This is close to the Pantlind Hotel.

The Committee Organization Luncheon, a meeting of MSMS committee chairmen appointed by President-elect A. S. Brunk, M.D., to serve during the year 1944-45, will be held on Wednesday, September 27, 12:30 p.m. in the Pantlind Hotel.

* * *

The American College of Chest Physicians, Michigan Chapter, will hold its annual meeting in the Pantlind Hotel, Grand Rapids, coincident with the MSMS Annual Session.

Dinner will be served on Thursday, September 28, 6:30 p.m., in the Amber Room of the Pantlind Hotel (second floor), followed by a meeting to which Herman H. Hilleboe, M.D., of Bethesda, Md., and Ralph C. Matson, M.D., of Portland, Ore., have been invited to speak. All members of the Michigan State Medical Society are invited to this Session. W. P. Chester, M.D., 2916 Seminole Avenue, Detroit 14, is in charge of arrangements; copies of the Program may be obtained by writing Dr. Chester.

* * *

Guest Golf—The Chairman of the Grand Rapids Committee has arranged that MSMS members may play at all country clubs in the Grand Rapids District upon presentation of MSMS Membership Card and payment of greens fees.

Due to the war, the regular MSMS Golf Tournament for 1944 has been cancelled.

SEVENTEEN DISCUSSION CONFERENCES

These quiz periods will be held Wednesday, Thursday, and Friday, September 27, 28, 29, at 4:00 to 5:00 p.m. An opportunity to ask questions concerning the presentation of the guest-essayists, or to discuss one of your interesting cases with them, will be provided.

Wednesday: Discussion Conferences on General Practice, Surgery, Dermatology, Otolaryngology, Obstetrics and Gynecology, and on Pathology.

Thursday: Discussion Conferences on Surgery, Industrial Health, Obstetrics, Ophthalmology, Medicine, and Anesthesia.

Friday: Discussion Conferences on Medicine, Gynecology and Obstetrics, Pediatrics, Dermatology and General Practice.

Please submit your questions, on forms printed in the Program† to the Secretary of the General Assembly immediately after the termination of the lecture, in order that the guest essayist may have time to consider same before the quiz period at 4:00 p.m.

†Forms facing page 16.

COUNTY SECRETARIES' CONFERENCE

Schubert Room, Pantlind Hotel
Wednesday, September 27, 1944
5:30 p.m. to 8:30 p.m.

T. Y. Ho, M.D., St. Johns, Presiding

Program

1. **The Michigan Picture in Medicine (10 minutes)**
   L. Fernald Foster, M.D., Bay City
   Secretary, Michigan State Medical Society
2. **Nebraska's New Medical Practice Act (20 minutes)**
   M. C. Smith, Lincoln, Nebraska
   Executive Secretary, Nebraska State Medical Association
3. **Health Insurance Proposals in Canada (20 minutes)**
   F. A. Brockenshire, M.D., Windsor, Canada
   Immediate Past President, Ontario Medical Association

All Members of the State Society Will Be Welcomed at this Conference

THE WOMAN'S AUXILIARY
to the
Michigan State Medical Society
Presents an
ATTRACTIVE PROGRAM
To which the wife of every MSMS member is cordially invited

Register at Every Booth—There is something for you in the interesting and large exhibit (118 booths). Stop and show your appreciation of the exhibitors' support in making the Postgraduate Conference possible.

* * *

Eight General Assemblies, Wednesday, Thursday, Friday, September 27, 28, 19. (See pages 793, 795, 796, 798, 799, 800.)

* * *

Ten Section Meetings on Wednesday, Thursday, Friday. All Sections will meet at luncheons in the Pantlind Hotel, 12:00 noon to 1:30 p.m. (See pages 795, 797, 800.)

* * *

The Loyola University Alumni of Michigan will hold a meeting in Grand Rapids on the occasion of the MSMS Annual Session.

Dinner will be served on Thursday, September 28, in the Michigan Room, Pantlind Hotel, 6:30 p.m. C. G. Krupp, M.D., 16 Monroe Avenue, N.E., Grand Rapids, is Chairman of Arrangements. All Loyola Alumni are cordially invited to attend this party.

TWO CINEMA ROOMS AT MSMS WAR CONFERENCE

Davis & Geck, Inc., of New York, and the Medical Film Guild of New York, will each present scientific films in their cinema rooms at the 79th Annual Session of the Michigan State Medical Society in Grand Rapids, September 27-28-29.

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From the **Surgical Film Library of Davis & Geck**, the following film program will be presented in Booth A-8:

WEDNESDAY, SEPTEMBER 27

8:30 A.M.-8:50 A.M.
Cataract Extraction
Dr. Ramon Castroviejo—Columbia Presbyterian Medical Center

9:00 A.M.-9:30 A.M.
The Application of Thick Split Skin Grafts
Dr. J. Barrett Brown—Washington Univ. School of Medicine

11:30 A.M.-12:00 M
Modified Mikulicz Operation. Right Colectomy for Carcinoma of the Cecum
Second Stage Resection of Right Colon—Closure of Modified Mikulicz.
Dr. Richard B. Cattell, Boston

1:30 P.M.-2:00 P.M.
Partial Gastrectomy after Failure of Gastroenterostomy to Cure a Duodenal Ulcer.
Dr. Roy D. McClure—Henry Ford Hospital, Detroit

3:30 P.M.-3:50 P.M.
Abdomino-Perineal Resection for Carcinoma of the Rectum, One-Stage Operation (Miles).
Dr. Thomas E. Jones—Cleveland Clinic

3:50 P.M.-4:00 P.M.
Removal of Pancreatic Stone.
Dr. Wm. F. Rienhoff, Jr.—Johns Hopkins Hospital

5:00 P.M.-5:45 P.M.
Surgery of the Common Bile Duct.
Dr. Chas. B. Puestow—Univ. of Illinois, School of Medicine

5:45 P. M.-6:00 P.M.
Reconstruction of Nose by Epithelial Inlay.
Dr. John M. Converse—American Hospital in Britain

THURSDAY, SEPTEMBER 28

8:30 A.M.-8:45 A.M.
Reconstruction of Floor of Orbit.
Dr. John M. Converse—American Hospital in Britain

8:45 A.M.-9:00 A.M.
Keratoplasty
Dr. Ramon Castroviejo—Columbia Presbyterian Medical Center

9:00 A.M.-9:30 A.M.
Cancer of the Female Breast, Diagnosis and Treatment.
Dr. Frank E. Adair, Memorial Hospital, New York

11:30A.M.-12:00 M
Skin Grafting of War Wounds and Observations on Wound Healing.
Dr. John M. Converse—American Hospital in Britain

1:30 P. M.-1:45 P. M.
Ileostomy for Ulcerative Colitis.
Dr. Henry W. Cave, New York

1:45 P.M.-2:00 P.M.
Colectomy for Ulcerative Colitis.
Dr. Henry W. Cave, New York

3:30 P.M.-4:00 P.M.
Cholelithiasis with Common Duct Stone.
Dr. Ralph Bettman—Rush Medical College, Chicago

5:00 P.M.-5:45 P.M.
Inguinal Hernia.
Dr. Raymond W. McNealy—Northwestern Univ. Medical School

5:45 P.M.-6:00 P.M.
Surgical Treatment of Varicose Veins with High Ligation and Individualized Stripping and Excision.
Dr. Henry N. Harkins—Henry Ford Hospital, Detroit

FRIDAY, SEPTEMBER 29

8:30 A.M.-8:40 A.M.
Subtotal Thyroidectomy for Multiple Nodular Goiter.
Dr. Roy D. McClure—Henry Ford Hospital, Detroit

8:40 A.M.-9:15 A.M.
Combined Operation: Fusion of Lumbosacral Joint and Hemilaminectomy for Removal of Herniated Disc.
The Lahey Clinic, Boston

9:15 A.M.-9:30 A.M.
Splenectomy for Banti's Disease.
Dr. Roy D. McClure—Henry Ford Hospital, Detroit

11:30 A.M.-11:45 A.M.
Subtotal Gastrectomy for Gastric Ulcer.
Dr. Wm. F. Rienhoff, Jr.—Johns Hopkins Hospital

11:45 A.M.-12:00 M.
Complete Laceration of the Perineum.
Dr. Louis E. Phaneuf, Boston

1:30 P.M.-2:00 P.M.
Treatment of War Burns of Hand.
Dr. John M. Converse—American Hospital in Britain

* * *

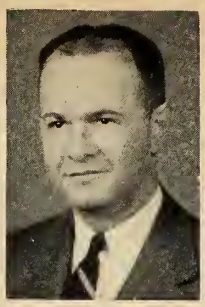
The Medical Film Guild's Library will show the following films daily in Booth A-16:

1. **Inguinal Hernioplasty**—In Color and Sound
Demonstrating the new Surgical Stitching Instrument designed for the advancement of Surgery.
2. **Sutures Since Lister**—In Sound
An instructive film portraying operative procedure of the period contemporary with Lister in contrast with present-day methods.
3. **Non-operative Treatment of Paranasal Sinusitis**—In Color and Sound
Designed to outline an intelligent approach to the conservative management of those sinus infections that are encountered in the daily routine.
4. **Otitis Media in Pediatrics**—In Color and Sound
The film portrays the importance of the infectious diseases of infancy and childhood in the development of otitic inflammations.
5. **A Clinic of Acute Mastoiditis**—In Color and Sound
Depicts the anatomy of the mastoid process, the importance of landmarks, the relationship of vital structures, the use of instruments and the operative procedure.
6. **Otoscopy in the Inflammations**—In Color and Sound
A series of ear drums are shown, from the acute catarrhal condition and chronic catarrhal condition to pictures of adhesive processes.
7. **A Clinic on Petrositis With Meningitis**—In Color and Sound
The symptoms of the patient are shown pictorially, with animated charts of the laboratory and clinical findings. Minimal surgery is stressed to meet current imperative indications.
8. **A Clinic on Sigmoid Sinus Thrombosis**—In Color and Sound
The anatomy, the genesis of the lesion, the symptomatology and operative therapy is presented as it occurred in an actual case.
9. **Asphyxia Neonatorum**—In Sound and Color
The many prevalent complications of childbirth, together with prophylaxis, judicious use of drugs, and care during labor and delivery are shown. Embryology and physiology of resuscitation are extensively outlined.
10. **A Clinic on Chronic Otitic Purulences**—In Sound and Color
Otoscopic examination and physical findings demonstrate the lesions in the dangerous and non-dangerous chronically discharging ear.
11. **Amebiasis and Its Treatment**—In Sound and Color
A thorough-going study of Amebic Dysentery emphasizing the many ramifications in diagnosis, epidemiology, pathology and treatment.
12. **Rehabilitation for Parkinson's Syndrome**—In Color and Sound
A diagnostic and surgical study of Parkinson's disease.

Guest Speakers



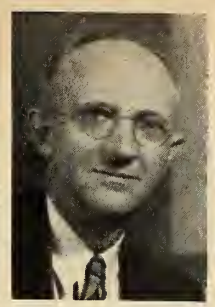
HARLES A. ALDRICH
Rochester, Minn.



A. A. APPLEBAUM
Toledo, Ohio



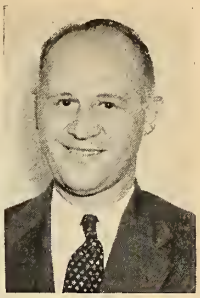
JOSEPH L. BAER
Chicago



S. WILLIAM BECKER
Chicago



PRESTON BRADLEY
Chicago



CHARLES J. CLARK
Willow Run, Mich.



ARTHUR C. CURTIS
Ann Arbor



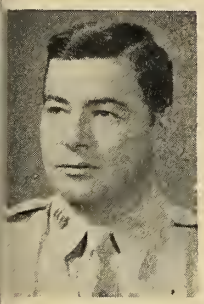
GEZA DE TAKATS
Chicago



FREDERICK H. FALLS
Chicago



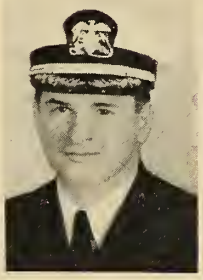
SIDNEY FARBER
Boston



CAPT. ARTHUR W. FRISCH
Battle Creek



JOHN W. HARRIS
Madison, Wis.



HERMAN E. HILLEBOE
Bethesda, Md.



BRIG. GEN. C. C. HILLMAN
Washington, D. C.



JOHN F. HUNT
Chicago



FRANK H. KRUSEN
New York



MAJOR FRANK H. MAYFIELD
Battle Creek



BRIG. J. C. MEAKINS
Montreal



COL. WM. C. MENNINGER
Washington, D. C.



ROBERT A. MOORE
St. Louis



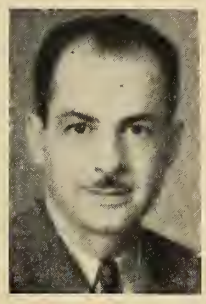
R. L. NOVY
Detroit



EARL D. OSBORNE
Buffalo



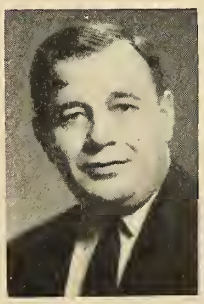
ARTHUR W. PROETZ
St. Louis



E. A. ROVENSTINE
New York



A. D. RUEDEMANN
Cleveland



TOM D. SPIES
Birmingham, Ala., and Cincinnati



JAMES L. WILSON
New York



MAX M. ZINNINGER
Cincinnati

Woman's Auxiliary



Mrs. J. J. Walch
President
1943-1944

COMMITTEE CHAIRMEN

Mrs. Willis L. Dixon.....General Chairman
Mrs. William J. Butler.....Co-Chairman
Registration and Credentials—Mrs. John TenHave
Hospitality—Mrs. A. Verne Wenger, Mrs. Carl Snapp
Finance—Mrs. John T. Hodgen
Press—Mrs. Henry P. Kooistra, Mrs. Floyd F. Gibbs
Flowers and Decorations—Mrs. John Mill Wright, Mrs. O. H. Gillette
Exhibits—Mrs. Robert H. Denham (Medical and Surgical Relief), Mrs. Wm. Rodger (Nutrition)
Pre-Convention Luncheon—Mrs. Merrill Wells
Banquet and Luncheon—Mrs. Wiliam A. Hyland, Mrs. Joseph DePree
Fashion Show—Mrs. John Winslow Holcomb, Mrs. Geo. Southwick
Tea—Mrs. Harvard J. VanBelois, Mrs. Russell Brink
Pages—Mrs. Ward Ferguson

Program

Tuesday, September 26, 1944

1:00 P.M. Registration opens

6:30 P.M. Dinner at Hotel Pantlind for Past Presidents and Secretaries Club of State Auxiliary.

Mrs. Guy L. Kiefer—President
Mrs. William J. Butler—Chairman
Mrs. A. Verne Wenger—Co-Chairman

Wednesday, September 27, 1944

9:00 A.M. Registration — Hotel Pantlind — Balcony

10:00 A.M. Finance Committee—

Mrs. H. L. French, Chairman

12:30 P.M. Pre-convention Luncheon and Board Meeting

Amber Room—2nd Floor—Hotel Pantlind—Complimentary 1943-1944 Board Members and County Presidents. All members welcome to attend.

3:30 P.M. Tea—Continental Room—1st Floor, Hotel Pantlind

Kent County Auxiliary Members—Hostesses

6:00 P.M. Reception Honoring Mrs. David W. Thomas, National President, and State Officers.

Mezzanine Floor

7:00 P.M. Banquet (Informal) Grill Room—1st Floor, Hotel Pantlind

Presiding—Mrs. John J. Walch, President
National Anthem—Led by R. J. McCandliss, M.D., accompanied by Mrs. McCandliss
Invocation—Mrs. Guy L. Kiefer
Welcome—Mrs. W. L. Dixon, Chairman
Presentations of Past Presidents, Speakers and honored guests
Fashion Show—Something unusual and different in the way of entertainment

Thursday, September 28, 1944

8:00 A.M. Registration—Hotel Pantlind

9:00 A.M. Formal Opening of Convention—Amber Room, Hotel Pantlind

Presiding—Mrs. John J. Walch, President
Pledge of Allegiance—Mrs. Wm. E. Barstow, St. Louis
Introductions:
Address of Welcome—Mrs. Merrill Wells, President Kent County Auxiliary
Response—Mrs. Lloyd C. Harvie, Saginaw
Greetings—Dr. F. E. Reeder, Chairman, Advisory Council
In Memorian—Mrs. W. A. Schaeffer
Report of Mrs. Willis L. Dixon, Convention Chairman
Minutes of the 17th annual meeting—Mrs. Otto S. Hult, Secretary.
Roll Call
Convention Rules of order—Mrs. Homer Ramsdall
Credentials and Registrations—Mrs. John TenHave, Chairman
Resoutions—Mrs. Riggs
President's Message—Mrs. John J. Walch
Report of Officers:
Treasurer—Mrs. R. H. Alter, Jackson
Auditor's Report
Secretary—Mrs. Otto Hult
Chairman of Standing Committees
County Presidents
New Business
Unfinished Business
Report of Committee on nominations
Elections of officers and installation
Presentation Ceremony—Mrs. Guy L. Kiefer
Address—Mrs. H. L. French, President
Adjournment

12:30 P.M. Annual Luncheon, Grill Room—1st Floor, Hotel Pantlind

Presiding—Mrs. Willis L. Dixon, Convention Chairman
Invocation—Rev. Edward A. Mohns, Pastor Westminster Presbyterian Church
Introductions of honored guests .
Speaker—Floyd E. Armstrong, Professor of Economics—M.I.T.
National Anthem

3:30 P.M. Post Convention Board Meeting—Mrs. H. L. French, Presiding

This is compulsory for 1944-1945 Board Members and County Presidents. All Members urged to attend.

1944 Postgraduate Conference on War Medicine

PROGRAM of GENERAL ASSEMBLIES

WEDNESDAY MORNING
September 27, 1944

First General Assembly

Black and Silver Ballroom, Civic Auditorium

R. S. Morrish, M.D., Presiding

L. Fernald Foster, M.D. and C. J. Smyth, M.D., Secretaries

A. M.

9:30 "Tropical Medicine"

Brigadier General C. C. Hillman, MC, U.S. Army, Washington, D. C.

Chief of Professional Service, Surgeon General's Office, War Department, Washington, D. C.

Since Pearl Harbor many thousands of our American physicians have become perforce doctors of tropical medicine. The problems that have been encountered in maintaining the health of troops in tropical climates among highly infected native populations have been legion. Each has necessitated detailed study and special measures to provide the solution. With typical American resourcefulness our medical officers have succeeded and, notwithstanding the unfavorable environment and hardships of campaign, death rates from disease among troops in tropical theatres have been far more favorable than among the civilian population of the United States.

The future suggests that for decades to come we shall have to maintain garrisons in equatorial areas. Tropical medicine becomes, therefore, a subject of practical interest and one that should command the earnest attention of our civilian practitioners and teaching institutions.

Our understanding of vascular disease is daily enlarging. Its recent progress is explained by newer knowledge pertaining to the dynamics of circulation and by a closer study of the changes occurring in the clotting mechanism. For the general practitioner the disturbances of peripheral circulation are most important. Acute vascular emergencies in the peripheral circulation include arterial thromboses, arterial emboli, and venous thromboses. The chronic vascular lesions are on an inflammatory, degenerative, or neurovascular basis. The purpose of treatment is obviously threefold: to relieve the obstruction, to develop and improve collateral circulation, and to remove nonviable parts at an optimal level.

10:00 "Vascular Disease"

Geza de Takats, M.D., Chicago, Illinois

Associate Professor of Surgery, University of Illinois; Senior Attending Surgeon, St. Luke's Hospital, Chicago.

Our understanding of vascular disease is daily enlarging. Its recent progress is explained by newer knowledge pertaining to the dynamics of circulation and by a closer study of the changes occurring in the clotting mechanism. For the general practitioner, the disturbances of peripheral circulation are most important. Acute vascular emergencies in the peripheral circulation include arterial thromboses, arterial emboli, and venous thromboses. The chronic vascular lesions are on an inflammatory, degenerative, or neurovascular basis. The purpose of treatment is obviously threefold: to relieve the obstruction, to develop and improve collateral circulation, and to remove nonviable parts at an optimal level.

10:30 "The Treatment of Eczema (Dermatitis) Based on Etiology"

Earl D. Osborne, M.D., Buffalo, New York

Professor of Dermatology and Syphilology, University of Buffalo School of Medicine; Member of Subcommittee on Industrial Medicine of National Research Council.

Most textbooks classify eczema (dermatitis) according to its clinical appearance and location. In the presenter's opinion this approach is entirely outmoded and signifies a lack of investigative and dermatologic detective ability in the elucidation of the cause of the eczema (dermatitis). In well over 90 per cent of cases of eczema (dermatitis) the cause can be found and eliminated. Studies on many cases of industrial dermatitis have taught us much regarding the etiology of eczema (dermatitis) in the whole population.

Illustrated cases of all types of eczema (dermatitis) based on etiology will be presented and the handling of these cases will be explained.

11:00 "The Pathology of Rickettsial Diseases"

Robert A. Moore, M.D., St. Louis, Missouri and Edward Mallinckrodt

Professor of Pathology, Washington University School of Medicine, St. Louis; Pathologist to the Barnes Hospital, St. Louis.

American physicians in the past have had little practical need for information on rickettsial diseases. In the 1930's an increasing number of patients with Rocky Mountain spotted fever have been observed in Midwestern and Eastern states. American troops are now stationed in parts of the world where louse-borne and flea-borne typhus and scrub typhus or tsutsugamushi fever are endemic or epidemic.

The essential anatomic lesion in rickettsial disease is an inflammation of vascular walls with secondary inflammation in certain viscera and tissues. The clinical signs and symptoms are directly related to the pathologic changes.

11:30 End of First General Assembly

HALF-HOUR INTERMISSION TO VIEW EXHIBITS

You Are Cordially Invited
to Visit the
Michigan State Medical Society
HOSPITALITY BOOTH
Opposite Registration Desk—Civic Auditorium
Stop and Chat With Your State Officers

PROGRAM of SECTIONS

Wednesday

September 27, 12:00 to 1:30 p.m. (luncheons)

SECTION ON GENERAL PRACTICE

Ballroom

Chairman: Carl S. Ratigan, M.D., Dearborn
Secretary: Paul E. Medema, M.D., Muskegon

"The Place of the General Practitioner in the Practice of Obstetrics"

John W. Harris, M.D., Madison

Under the present setup of medical practice, the general practitioner must of necessity still assume the responsibility for the care of the majority of obstetric patients. If this is to be done properly, certain changes must be made in present-day procedures. The most important of these is the education of the public as to the value of preventive obstetrics. In turn, obstetrics can and should be made more attractive to the general practitioner.

(Continued on Page 795)

Seventeen Discussion Conferences (Quiz Periods)

All Meetings in the Pantlind Hotel and Civic Auditorium, Grand Rapids

Seventeen discussion conferences each with a different chairman—leaders of outstanding ability in their field—will be held Wednesday, Thursday, and Friday afternoons. Here the doctor will have a chance to ask questions of the lecturers he has heard and to hear discussed medical matters of value to him in his daily practice.

Wednesday, September 27—4:00 to 5:00 p.m.

GENERAL PRACTICE	SURGERY	DERMATOLOGY	PATHOLOGY	OBSTETRICS	OTOLARYNGOLOGY
Ballroom, Pantlind Hotel Leader **Walter A. Stryker, M.D.** Ann Arbor Guest Conferee **General C. C. Hillman, MC** Washington, D. C.	Black and Silver Ballroom Civic Auditorium Leader **Edward H. Lauppe, M.D.** Detroit Guest Conferee **Geza de Takats, M.D.** Chicago	Room F Civic Auditorium Leader **Udo J. Wile, M.D.** Ann Arbor Guest Conferee **Earl D. Osborne, M.D.** Buffalo	Grill Room Pantlind Hotel Leader **D. C. Beaver, M.D.** Detroit Guest Conferees **Robert A. Moore, M.D.** St. Louis **Capt. Arthur W. Frisch, MC** Battle Creek	Schubert Room Pantlind Hotel Leader **Roger S. Siddall, M.D.** Detroit Guest Conferee **John W. Harris, M.D.** Madison, Wis.	Red Room Civic Auditorium Leader **H. Lee Simpson, M.D.** Detroit Guest Conferee **Arthur W. Proetz, M.D.** St. Louis, Mo.

Thursday, September 28—4:00 to 5:00 p.m.

INDUSTRIAL HEALTH	SURGERY	ANESTHESIA	MEDICINE	OBSTETRICS	OPHTHALMOLOGY
Grill Room Pantlind Hotel Leader **C. D. Selby, M.D.** Detroit Guest Conferee **Frank H. Krusen, M.D.** Rochester, Minn.	Black and Silver Ballroom Civic Auditorium Leader **F. A. Coller, M.D.** Ann Arbor Guest Conferees **Major Frank H. Mayfield, MC** Battle Creek **Max M. Zinninger, M.D.** Cincinnati	Room F Civil Auditorium Leader **Reuben Maurits, M.D.** Grand Rapids Guest Conferee **Emery A. Rovenstine, M.D.** New York	Ballroom Pantlind Hotel Leader **John Barnwell M.D.** Ann Arbor Guest Conferee **Herman E. Hilleboe, M.D.** Bethesda, Md.	Schubert Room Pantlind Motel Leader **Ward F. Seeley, M.D.** Detroit Guest Conferee **Joseph L. Baer, M.D.** Chicago	Red Room Civic Auditorium Leader **J. O. Wetzel, M.D.** Lansing Guest Conferee **A. D. Ruedemann, M.D.** Cleveland

Friday, September 29—4:00 to 5:00 p.m.

GENERAL PRACTICE	PEDIATRICS	DERMATOLOGY	MEDICINE	OBSTETRICS	
Grill Room Pantlind Hotel Leader **R. W. Waggoner, M.D.** Ann Arbor Guest Conferee **Col. Wm. C. Menninger, MC** Washington, D. C.	Black and Silver Ballroom Civic Auditorium Leader **John H. Law, M.D.** Ann Arbor Guest Conferees **A. C. Aldrich, M.D.** Rochester, Minn. **Sidney Farber, M.D.** Boston **James L. Wilson, M.D.** New York	Room F Civic Auditorium Leader **John H. Cobane, M.D.** Detroit Guest Conferees **S. Wm. Hecker, M.D.** Chicago **A. C. Curtis, M.D.** Ann Arbor	Ballroom Pantlind Hotel Leader **B. R. Corbus, M.D.** Grand Rapids Guest Conferees **C. J. Clark, M.D.** Willow Run **A. A. Applebaum, M.D.** Toledo, Ohio **Brigadier J. C. Meakins** Montreal, Canada	Schubert Room Pantlind Hotel Leader **Harold Henderson, M.D.** Detroit Guest Conferee **Frederick H. Falls, M.D.** Chicago	**VIEW THE 118 EXHIBITS DAILY**

All Members Are Invited to Join in These QUIZ PERIODS With the Guest Essayists

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Grill Room

Chairman: W. S. Gonne, M.D., Detroit
Vice Chairman: R. C. Pochert, M.D., Owosso
Secretary: A. J. Cortopassi, M.D., Saginaw
Vice Secretary: Geo. C. Hardie, M.D., Jackson

OTOLARYNGOLOGICAL PROGRAM

"Allergy in the Ear, Nose and Throat"

Arthur W. Proetz, M.D., St. Louis, Missouri

Allergy in the ear, nose and throat will be discussed from a single standpoint: namely, the practical management of the disease in office and hospital by the otolaryngologist, with special emphasis upon his facilities and his limitations.

SECTION ON RADIOLOGY, PATHOLOGY, AND ANESTHESIA

Furniture Assembly Room

Chairman: R. J. Parsons, M.D., Ann Arbor
Secretary: C. B. Pillsbury, M.D., Ypsilanti
Secretary: H. J. Van Belois, M.D., Grand Rapids

PATHOLOGY PROGRAM

(a) **"Nodular Hyperplasia of the Prostate"** (20 min.)

Robert A. Moore, M.D., St. Louis, Missouri

Nodular hyperplasia (benign hypertrophy) of the prostate increases in incidence with increasing age, until 75 per cent of men over 80 years of age are affected. The essential lesion is a proliferation of stroma and glands in the lateral and medial parts of the prostate to form nodules. The physiologic disturbance is a partial obstruction at the vesical neck.

Of the many theories of cause and pathogenesis which have been suggested, the hypothesis implicating some dystrophy of hormones is the most logical and fits the facts best. If it is a hormonal imbalance, prevention is possible.

(b) **"Sulfonamide Resistant Gonorrhea"** (20 min.)

Captain Arthur W. Frisch, MC, AUS, Laboratory Service, Percy Jones General Hospital, Battle Creek, Michigan

The term "sulfonamide resistant" gonorrhea has acquired a clinical rather than a bacteriological connotation. Failure of patients to respond to treatment may be due to (1) inadequate dosage; (2) obstruction to effective drainage of pus in one or more foci within the glandular elements of the genito-urinary tract; (3) failure of the drugs to penetrate the infected tissue; or, (4) the development of "fastness" to one or more of the sulfonamides. For the above reasons a simple method of determining bacteriologic sensitivity was devised in which urethral exudates were cultured on media containing sulfonamides and penicillin and the growth of gonococci was compared with a control plate without drugs.

Among clinically resistant cases of male gonorrhea only 37 per cent were found to harbour organisms which had acquired tolerance for sulfathiazole. On the other hand all of the bacteriologically resistant cultures were susceptible to the action of penicillin. The management of these cases is discussed.

WEDNESDAY AFTERNOON
September 27, 1944

Second General Assembly

Black and Silver Ballroom, Civic Auditorium

C. E. Umphrey, M.D., Presiding
L. Fernald Foster, M.D., and Milton A. Darling, M.D., Secretaries

P. M.

2:00 "Vitamins and the Practice of Medicine"

Tom D. Spies, M.D., Birmingham, Alabama and Cincinnati, Ohio

Associate Professor of Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio; Director, Nutrition Clinic Hillman Hospital, Birmingham, Alabama.

The very essence of good medical practice is precise diagnosis followed by persistent and adequate therapy. Most physicians recognize the so-called textbook case of deficiency disease and know how to treat it, but to date the practicing physician has been taught little about the early case, the case with asymmetrical lesions or the very severe case with atypical lesions. It is with this group of cases that I shall spend most of my time for to miss the diagnosis here and fail to apply the usual therapy allows a fatality. In the fine evaluation of every case we have in mind that correct diagnosis can be made only by the interpretation of a careful dietary history, indicated laboratory tests and a thorough medical history, and physical examination. After the diagnosis is made, we apply the following four principles of therapy.

1. Diet: 4,000 calories, 120-150 gm. protein, rich in vitamins and minerals.
2. Basic therapy: thiamin, riboflavin, niacin amide, ascorbic acid, orally.
3. Additional medication: synthetic vitamins as indicated, orally or parenterally.
4. Natural B Complex: brewers' yeast or extract, or rice bran extract, and/or liver extract orally or parenterally.

2:30 "The Obstetricians' Responsibility in the Problem of Prematurity"

John W. Harris, M.D., Madison, Wisconsin

Professor of Obstetrics and Gynecology, University of Wisconsin; Obstetrician and Gynecologist-in-Chief, State of Wisconsin General Hospital.

Remarkable strides have been made in the feeding and care of the premature infant. However, the number of stillbirths and deaths within the first day of life remains appallingly high. This is the chief responsibility of the obstetrician. The causes of prematurity are reviewed, and, in certain cases, methods for reducing its incidence are discussed. The conduct of premature labor and especially as regards the choice of analgesic and anesthetic drugs are of vital importance and are evaluated in detail.

3:00 "Management of the Common Cold"

Arthur W. Proetz, M.D., St. Louis, Missouri

Professor of Clinical Otolaryngology, Washington University School of Medicine; Editor of the "Annals of Otology, Rhinology and Laryngology."

The common cold is a combination of more or less constant symptoms attendant upon the sudden invasion of the upper—and sometimes the lower—respiratory tract. The distressing result, however, may be brought about by any of several causes. Until something specific is discovered which will either prevent or cure a cold, management must be largely dependent upon the etiological factions operating in the case in hand. Recovery depends upon the reëstablishment of physiological conditions. Means will be discussed for bringing this about in given cases. Treatment will be discussed from the standpoints of prevention, amelioration of symptoms and shortening the course of the attack.

3:30 HALF-HOUR INTERMISSION TO VIEW EXHIBITS

4:00 SIX DISCUSSION CONFERENCES WITH GUEST ESSAYISTS (See page 794)

5:00 End of Second General Assembly

WEDNESDAY EVENING
September 27, 1944

Third General Assembly

Ballroom, Pantlind Hotel, Grand Rapids

C. R. Keyport, M.D., Presiding
L. Fernald Foster, M.D., Secretary

P. M.
8:30 OFFICERS' NIGHT—PUBLIC MEETING

1. **Call to order by President C. R. Keyport, M.D., Grayling**
2. **Announcements and Reports of the House of Delegates by Secretary L. Fernald Foster, M.D., Bay City**
3. **President's Annual Address—C. R. Keyport, M.D.**
4. **Induction of A. S. Brunk, M.D., Detroit, into office as President of the Michigan State Medical Society. Response**
5. **Presentation of Scroll and Past-President's Key to Dr. Keyport by the Chairman of the Council, V. M. Moore, M.D., Grand Rapids**
6. **Introduction of the President-Elect and other newly elected officers of the State Society**

9:00 7. **The Andrew P. Biddle Oration**
"When Doctors Disagree"

Preston Bradley, LL.D., D.D., Chicago



Preston Bradley

8. **Presentation of Biddle Oration Scroll**



Patron of Postgraduate Medical Education (Deceased, August 2, 1944)

A. P. Biddle, M.D.

End of Third General Assembly

THURSDAY MORNING
September 28, 1944

Fourth General Assembly

Black and Silver Ballroom, Civic Auditorium

O. O. Beck, M.D., Presiding
L. Fernald Foster, M.D. and Wm. G. Wander, M.D., Secretaries

A. M.
9:30 "Gall Bladder"

Max M. Zinninger, M.D., Cincinnati, Ohio

Associate Professor of Surgery, College of Medicine, University of Cincinnati.

The physiologic function of the gall bladder is concentration and storage of bile in the intervals between digestive activity. As a result of disease, either metabolic or infectious, this function may be altered or abolished, stones may form, and digestive disturbances occur. The rational treatment of cholecystic disease is cholecystectomy to remove the focus of infection which is principally in the wall of the gall bladder, and to remove the nidus for further stone formation. Symptoms, diagnosis and pathology will be reviewed. The management of acute cholecystitis will be discussed. A few details of operative technique will be mentioned.

10:00 "The Protruding Eye"

A. D. Ruedemann, M.D., Cleveland, Ohio

Head of Eye Department, Cleveland Clinic

The protruding eye will be discussed from the point of view of early diagnosis and treatment.

It is important that an effort be made to make an early diagnosis as the functional end result depends upon the position of the eyes themselves. Watchful waiting is not a good criterion to follow in these cases. All the diagnoses are made by exclusion by the use of x-rays, blood counts, nose and throat examination, general physical examination, especially in those patients probably having thyroid disease. They present an interesting but difficult group and provide considerable discussion as to the best methods of treatment.

An attempt will be made to interest the general man in early recommendations as to the diagnosis and treatment of this very serious eye condition.

10:30 "Prolonged Labor"

Joseph L. Baer, M.D., Chicago, Illinois

Rush Professor of Gynecology and Obstetrics, University of Illinois; Senior Attending Gynecologist and Obstetrician, Michael Reese Hospital; Co-Chairman Cook County Maternal Welfare Committee.

The phrase "Prolonged Labor" is clinical in concept and application. Since clinical judgment and experience is necessarily personal there can be no scientific determination of what constitutes prolonged labor. In each instance a multitude of factors must be taken into consideration. In competent hands an impassable bony pelvis, obstructing tumors, transverse presentation, hydrocephalus, et cetera, will have been detected before the onset of labor. Ineffectual contractions, relative cephalo-pelvic disproportions, maternal exhaustion, unusual fetal positions and attitudes, threatened rupture of the uterus, resistant pelvic floor, contribute to the clinical picture. An arbitrary twenty-four hour time limit is applicable only in relation to the clinical evaluation of the status of the parturient and the fetus.

VIEW THE 118 EXHIBITS
SCIENTIFIC AND TECHNICAL

11:00 "The Pre-anesthetic Preparation of the Surgical Patient"

E. A. ROVENSTINE, M.D., New York, N. Y.

Professor of Anesthesia, New York University College of Medicine; Director, Division of Anesthesia, Bellevue Hospital, New York.

Anesthesia should be considered as the summation of the effects of premedication and the anesthetic agent proper. The selection of drugs for pre-anesthetic preparation, the amounts used and the time of administration are common sources for errors in the technique of anesthesia.

Pre-anesthetic medication has developed in a wide range from "an aspirin tablet" to "basal narcosis." A wide variety of drugs is in popular use. The rational of such therapy, the results desired and the consequences of its improper application to clinical surgery are discussed.

11:30 End of Fourth General Assembly

HALF-HOUR INTERMISSION TO VIEW EXHIBITS

——PROGRAM of SECTIONS——

Thursday

September 28, 12:00 to 1:30 p.m. (luncheons)

SECTION ON SURGERY

Ballroom

Chairman: ROBERT H. BAKER, M.D., Pontiac
Secretary: LOUIS J. MORAND, M.D., Detroit

"Herniated Nucleus Pulposus"

MAJOR FRANK H. MAYFIELD, MC, AUS, Percy Jones General Hospital, Battle Creek, Michigan

Injuries to the intervertebral disc have been recognized with greater frequency as a cause of low-back and sciatic pain within the past few years, and are at the present time a major military as well as an industrial problem.

The author will give a general discussion of this disease. This will include the diagnosis, treatment, and analysis of results.

SECTION ON GYNECOLOGY AND OBSTETRICS

Schubert Room

Chairman: MILTON A. DARLING, M.D., Detroit
Secretary: CLEARY N. SWANSON, M.D., Detroit

"Office Gynecology"

JOSEPH L. BAER, M.D., Chicago

Gynecological practice includes something more than the detection of tumors, chronic pus tubes and birth injuries and their appropriate surgical treatment. Every leukorrhea is not a trichomonad infection, every backache is not an orthopedic problem, every cystitis does not respond to urinary antiseptics, dyspareunia cannot be shrugged off, sterility and infertility tax our skill and our patience. The endocrine vagaries of the adolescent, the kaleidoscopic manifestations of the menopause are a constant challenge. The potentialities of the cautery, the pessary, the dilators, the Rubin apparatus must be understood to be used intelligently. The flood of organic and synthetic preparations competing for our favor have a nucleus of value and so does the lowly blood count.

* * *

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Furniture Assembly Room

Chairman: WM. S. GONNE, M.D., Detroit
Vice Chairman: R. C. POCHERT, M.D., Owosso
Secretary: A. J. CORTOPASSI, M.D., Saginaw
Vice Secretary: GEO. C. HARDIE, M.D., Jackson

OPHTHALMOLOGICAL PROGRAM

"Beta Radium"

A. D. RUEDEMANN, M.D., Cleveland

Head of Eye Department, Cleveland Clinic

The use of beta radium in the treatment of corneal lesions, in the removal of corneal nebulæ, and in the reduction of the size of corneal maculæ and leukoma will be discussed. This treatment has been carried out in approximately two hundred patients having all types of corneal disturbances, and a report will be given as to its value in various types of corneal disturbances.

* * *

SECTION ON RADIOLOGY, PATHOLOGY, AND ANESTHESIA

Blue Room

Chairman: R. J. PARSONS, M.D., Ann Arbor
Secretary: C. B. PILLSBURY, M.D., Ypsilanti
Secretary H. J. VANBELOIS, M.D., Grand Rapids

ANESTHESIA PROGRAM

Discussion on "The Management of Postoperative Period"

Discussion Leader: MARY LOU BYRD, M.D., Grand Rapids
Guest Discussant: E. A. ROVENSTINE, M.D., New York, N. Y.

View the 118

Scientific and

Technical Exhibits

Daily

THURSDAY AFTERNOON
September 28, 1944

Fifth General Assembly

Black and Silver Ballroom, Civic Auditorium

E. F. Sladek, M.D., Presiding

L. Fernald Foster, M.D., and C. S. Ratigan, M.D., Secretaries

P. M.

2:00 **"A Rehabilitation Program for Military Veterans"**

Frank H. Krusen, M.D., New York, N. Y.

Professor of Physical Medicine, Mayo Foundation, University of Minnesota; Head of the Section on Physical Medicine, The Mayo Clinic; Director of the Baruch Committee on Physical Medicine.

The world is facing its greatest problem in physical rehabilitation. A satisfactory over-all program must be developed.

The physical reconstruction of those disabled in war begins at the moment of injury and ends only when they are restored physically and adjusted mentally. Rehabilitation is accomplished in nine steps: (1) immediate emergency care; (2) secondary emergency care; (3) rapid transportation; (4) treatment in general hospitals; (5) treatment in rehabilitation centers; (6) vocational guidance; (7) vocational training; (8) selective placement; (9) industrial rehabilitation.

Following all previous wars, physical rehabilitation has been performed rather poorly. Physicians must begin at once to consider the contributions which they can make toward the solution of this vast problem. This time we must not fail.

2:30 **"The Role of the General Practitioner in Tuberculosis Control"**

Herman E. Hilleboe, M.D., Bethesda, Maryland

Medical Director; Chief, Tuberculosis Control Division, U. S. Public Health Service.

Eugene J. Gillespie, M.D.

Senior Assistant Surgeon

The control of tuberculosis in general practice outside the cities constitutes a real problem, the solution of which is almost entirely dependent upon the interest and coöperation of the rural physician.

Tuberculosis is still an important public health problem in the United States, resulting in nearly 60,000 preventable deaths each year with ten times that number chronically disabled. A national program is just being established by the U. S. Public Health Service to assist the states and local communities in eradicating this disease.

The general practitioner with the aid of newer knowledge of tuberculosis, can play an important part in this great public health effort. Techniques of early and correct diagnosis and follow-up examinations are discussed with the suggestion that these procedures be applied on a wide scale by the family doctor in order that he may play his rightful role in the control of this disease.

3:00 **"Peripheral Nerve Injuries"**

Major Frank H. Mayfield, MC, AUS, Battle Creek, Michigan

Chief of the Neurosurgical Section, Percy Jones General Hospital, Battle Creek, Michigan

Injuries to peripheral nerves constitute approximately 10 per cent of war casualties. The writer's experience in the treatment of approximately 200 cases of peripheral nerve injuries will be given, along with a summary of the literature and a general discussion of the diagnosis, operative treatment, and postoperative care of such injuries.

3:30 **Half-hour Intermission to View Exhibits**

4:00 **SIX DISCUSSION CONFERENCES WITH GUEST ESSAYISTS** (See page 794.)

5:00 **End of Fifth General Assembly**

THURSDAY EVENING
September 28, 1944

Sixth General Assembly

Ballroom, Pantlind Hotel

A. S. Brunk, M.D., Presiding

L. Fernald Foster, M.D., and R. C. Pochert, M.D., Secretaries

P. M.

8:30 **STATE SOCIETY NIGHT** (Admission by card)

"What the People of Michigan Think of Medicine"

R. L. Novy, M.D., Detroit

John F. Hunt, Chicago



R. L. Novy, M.D.

Professor of Clinical Medicine, Wayne University College of Medicine; President of Michigan Medical Service.



John F. Hunt

Executive and Director of Research, Foote, Cone and Belding, Chicago.

A presentation of the results of a state-wide survey of public opinion relative to medical problems of the day will be made. The position of the medical profession in guiding and meeting the trends of the time will be discussed in light of the facts so presented.

9:15 **Discussion Period**
End of Sixth General Assembly

10:00 **Adjourn to Supper Club Room**

FRIDAY MORNING
September 29, 1944

Seventh General Assembly

Black and Silver Ballroom, Civic Auditorium

W. H. HURON, M.D., Presiding

L. FERNALD FOSTER, M.D., and ROBERT H. BAKER, M.D., Secretaries

A. M.

9:30 "Primary Atypical Pneumonia"

A. A. APPLEBAUM, M.D., Toledo, Ohio

Senior Active Staff Medical Service, St. Vincent's Hospital; Attending Physician, Toledo Hospital and Lucas County Hospital; Director of Cardiology at Lucas County Hospital and Women's and Children's Hospital; Consulting Physician, Toledo Society for Crippled Children; Fellow of the American College of Physicians.

Since primary atypical pneumonia has only in recent years been described, and is so commonly seen, a review of the subject is quite timely. It has become a serious problem in civilian life, as well as in the Armed Forces. This condition is, perhaps, better known as "virus pneumonia," although no virus has been definitely isolated as the etiologic agent. The predominant features are the relative scarcity of physical signs and failure to respond to sulfonamides and penicillin. A clinical study of 165 cases will be given, including one case report with post mortem findings. The discussion will include a survey of the etiology and epidemiology of the condition, the clinical features, diagnosis including the roentgenologic characteristics, pathologic findings, and treatment.

10:00 "Neuropsychiatry and the General Practitioner, Lessons Learned from the Army"

COLONEL WILLIAM C. MENNINGER, MC, Washington, D. C.

Director of the Division of Neuropsychiatry, Office of the Surgeon General, Army Service Forces, Washington, D. C.

In the army, if a man cannot function as a full duty soldier, he of necessity must go to the hospital. As a result, the medical officer sees many types of illness much earlier than in civilian life. Some of these are emotional difficulties and every medical officer has become aware of the fluidity of the soma and the psyche in the production of symptoms: gastric, cardiac, orthopedic, and in every body system. The problems arising concern themselves with the understanding of this type of symptomatology: what is the significance of such symptoms? What is the best approach to elucidation and understanding of them? What are the most effective treatment measures for such? The author attempts to answer these questions.

10:30 "Some Organic Digestive Disturbances in Early Life (Nature, Diagnosis and Treatment)"

SIDNEY FARBER, M.D., Boston, Massachusetts

Assistant Professor of Pathology, Harvard Medical School; Pathologist to the Children's Hospital, Boston.

This paper is concerned with chronic wasting and disturbance of nutrition, associated with foul stools and loss of fat and nitrogen in the feces. The causes of this disturbance of nutrition include diseases of the pancreas and of the intestinal tract and the attachments of the digestive tract. Differentiation of these organic disturbances from somewhat similar disorders of functional nature can be made and is necessary if correct treatment of these serious disorders is to be applied. The relation of the underlying pathologic processes to obstruction of the intestine in the newborn and to a generalized disease involving many organs in the body will be described. Application of these studies on infants and children to similar, and in part unrecognized, disturbances of nutrition in adults will be stressed. A logical classification summarizing present knowledge of the nature and diagnostic characteristics of these organic digestive disturbances with specific indications for their treatment will conclude the paper.

11:00 "Penicillin in the Treatment of Syphilis"

S. WILLIAM BECKER, M.D., Chicago, Illinois

Clinical Professor of Dermatology, University of Chicago.

Penicillin has been used (under the auspices of the Committee on Medical Research—Office of Scientific Research and Development, and the National Research Council) in the treatment of syphilis in rabbits in research institutes and in human beings in treatment centers throughout the United States. Early research was carried out for evaluation of various systems of treatment for early syphilis. The work was later expanded to include treatment of patients with various types of late syphilis. Treatment has been carried out by means of penicillin alone and in combination with other agents, such as mapharsen. Sufficient time has not elapsed to permit final evaluation, but encouraging results have been obtained, which will be presented.

11:30 End of Seventh General Assembly

HALF-HOUR INTERMISSION TO VIEW EXHIBITS

——PROGRAM of SECTIONS——

Friday

September 29, 12:00 to 1:30 p.m. (luncheons)

SECTION ON GENERAL MEDICINE

Chairman: CHARLEY J. SMYTH, M.D., Eloise

Secretary: JOHN D. LITTIG, M.D., Kalamazoo

(a) **"Recent Advances in the Treatment of Syphilis"** (20 min.)

ARTHUR C. CURTIS, M.D., Ann Arbor

Professor of Dermatology and Syphilology, University of Michigan.

Serologic tests used in syphilis are not specific, During recent years, as these tests have been made more sensitive, their dependability to diagnose syphilis has decreased in about the same proportion. There are at least 45 diseases known which will produce false positive reactions. As a result the interpretation of serologically positive tests today is a problem of great importance to the physician in order to prevent the diagnosis and treatment of syphilis in those who do not have the disease.

Since the valuable contribution on the course of untreated syphilis reported by Bruusgaard and the rather extensive studies on the effect of various amounts of treatment in the prevention of central nervous system and cardiovascular syphilis reported from the Johns Hopkins Group, our knowledge of the natural history annd prognosis of syphilis has been considerably extended. The introduction of new drugs (Phenylarsine-oxy-hydrochloride penicillin) for the treatment of syphilis and the results of the use of these drugs in the form of intravenous drip and multiple injections in the treatment of acute and late syphilis and syphilis in pregnancy will be discussed.

(b) **"What We Have Learned About Aviation Medicine"** (20 min.)

CHARLES J. CLARK, M.D., Flight Surgeon, Willow Run, Michigan, and HARRY BRITTON, M.D., Assistant Flight Surgeon, Willow Run, Michigan

The subject of Aviation Medicine should have a strong appeal, not only to those specifically interested in this subject as a specialty but also to regular medical students and to those engaged in the program of general medicine. At the present time, between two and three millions of our population take to the air each year and the time has come when no physician can remain totally ignorant of the effect of flying on the human organism, and at the same time be prepared to intelligently advise, treat, or examine those interested in flying whether it be as pilot or as a passenger. In certain circumstances aerial environment may be more deadly than any plague and every properly-trained physician should possess a general knowledge of avia-

tion medicine just as he possesses a general knowledge of other special fields of medicine. The advances in aviation medicine have been so rapid in recent years that it is almost impossible not to overlook valuable contemporary work. It should be borne constantly in mind that aviation medicine, which has heretofore been regarded as a rather disconnected collection of parts of several other medical specialties, should now be presented as a distinct and special entity in itself.

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SECTION ON PEDIATRICS

Grill Room

Chairman: Jos. A. Johnston, M.D., Detroit
Secretary: Mark F. Osterlin, M.D., Traverse City

"A Preventive Medical Program as Applied to Pediatrics"

Charles A. Aldrich, M.D., Rochester, Minn.

Professor of Pediatrics, Graduate School, University of Minnesota; Director, Preventive Medicine in Pediatrics, Mayo Clinic.

A complete preventive medical program for children must take into account not only the purely physical welfare of youngsters, but also their emotional and mental growth. This is true because it is impossible to separate the two in clinical medicine. How habit formation proceeds in such basic functions as eating, sleeping and eliminating will, of necessity, influence the child's emotional reactions as well as his physical well-being.

If a medical program could be devised which would attain our objectives from a health standpoint and at the same time co-operate with the child's natural developmental plan, we might look forward to a new type of individuality in our children. This is related to the development of a co-operative citizenry which a democracy so evidently needs.

The plan of the Rochester Child Health Project is outlined.

* * *

SECTION ON DERMATOLOGY AND SYPHILOLOGY

Furniture Assembly Room

Chairman: Wm. G. Wander, M.D., Detroit
Secretary: Ruth Herrick, M.D., Grand Rapids

"A New Interpretation of Some So-called Positive Patch-Tests, with Special Reference to Metals Used in Industry"

S. Wm. Becker, M.D., Chicago

The patch-test consists of application of chemical substances directly onto the skin, to imitate as nearly as possible contact which a person may have made with such substances in occupations, industry, or in the ordinary walks of life. A positive result is characterized by erythema, edema, vesiculation, exudation and crusting, a reaction due to epidermal hypersensitiveness to the substance, as seen in the vesicular reaction to poison ivy extract. Certain metals, notably nickel and chromium in their various compounds, occasionally produce reactions characterized by erythema, severe edema, follicular involvement and secondary vesiculation. An interpretation of the significance of such reaction is presented and industrial implications are discussed.

FRIDAY AFTERNOON
September 29, 1944

Eighth General Assembly

Black and Silver Ballroom, Civic Auditorium

V. M. Moore, M.D., Presiding

L. Fernald Foster, M.D., and Joseph A. Johnston, M.D., Secretaries

P. M.

2:00 "What a Modern Army Health Service Should Be"

Brigadier J. C. Meakins, M.D., Montreal, Canada

Professor of Medicine, McGill University Faculty of Medicine, Montreal, Quebec, Canada

The orthodox concept that an Army Medical Corps is primarily concerned with the prevention of communicable diseases and the curing and healing of specific lesions and injuries is far too restricted. Unfortunately the greater part of the officer personnel are imbued with this idea as it is fostered by the traditional principles of medical education and the requirements of licensing bodies. It is not fully appreciated nor practised that the Army comprises a selected group each member of which is presumably above a certain minimum standard of psysiological and psychological fitness. It is the duty of the Medical Corps to provide a Health Service in its broadest meaning and therefore must deal with soldiers from the anatomical, physiological, psychological and social points of view, always bearing in mind that he is being trained to fulfill a role entirely foreign to that of civil life.

2:30 "Obstetrical Hemorrhages"

Frederick H. Falls, M.D., Chicago, Illinois

Professor of Obstetrics and Gynecology, University of Illinois.

Obstetrical hemorrhage may be divided into three main groups: anti partum, post partum and miscellaneous hemorrhages.

Placenta previa presents special problems in management due to the period of gestation at which hemorrhage occurs, and effect on the baby of normal delivery because of abnormal anatomical relationships between the placenta and uterus.

Premature detachment of the placenta creates special problems because of the damage to the uterine muscle produced in some cases by over-distention.

Post partum hemorrhage presents a problem in differential diagnosis of the cause of hemorrhage, and application of the proper remedy without undue delay.

Miscellaneous hemorrhages caused by blood dyscrasias, cervical cancer, tears of perineal arteries and cervical polyps are discussed individually.

3:00 "Advance in the Prevention and Treatment of Poliomyelitis"

James L. Wilson, M.D., New York, N. Y.

Professor of Pediatrics, New York University; Chief of Bellevue Children's Medical Service; Associate Editor, Am. Journal of Diseases of Children.

Newly-acquired knowledge regarding the dissemination of the virus of poliomyelitis suggests no effective method for preventing its spread and makes our traditional public health procedures appear even more futile.

No inoculum has been invented which effectively increases resistance to the virus, although encouraging animal experiments have been carried out.

During the past few years discussions of treatment have been dominated by the Kenny physiotherapy technique. This method has been widely but uncritically accepted without even quantitative clinical observations, to say nothing of controlled clinical researches, having been carried out. It is unfortunate, particularly in dealing with poliomyelitis, that physicians and institutions could not have withstood the pressure for publicity until proper studies were made. Time-supported opinion seems progressively pessimistic regarding the results of the Kenny technique.

The theory behind the Kenny technique, developed apparently in retrospect after almost fettish-like details had been established, although physiologically and pathologically naïve has, however, stimulated many researches which will prove of great value.

3:30 Half-hour Intermission to View Exhibits

4:00 FIVE DISCUSSION CONFERENCES WITH GUEST ESSAYISTS (See page 794)

5:00 End of Eighth General Assembly

END OF SCIENTIFIC SESSION

SCIENTIFIC EXHIBITS

I. Committee on Cancer Control, MSMS, and Michigan Department of Health

"EARLY DIAGNOSIS OF CANCER"

This exhibit shows the family physician what he can and should do in examining his patients for cancer. A panel of instruments used in the examination, and charts of what can be seen, felt, and heard, early signs of cancer, and percentage of curability in early and late stages, are shown. A descriptive pamphlet is available.

II. Michigan Anesthesia Society

"THE DEVELOPMENT OF ANESTHESIA MACHINES FOR THE USE OF NITROUS OXIDE"

A tribute to Horace Wells, the first to use nitrous oxide anesthesia. An exhibit on the development of anesthesia machines for the use of nitrous oxide by diagrams showing the fundamental principles involved in the volution of our modern gas machine.

III. Michigan Crippled Children Commission

"CRIPPLED AND AFFLICTED CHILD PROGRAM"

Maxwell Reynolds, member of the Crippled Children Commission, will exhibit and demonstrate the simple emergency type of respirator which he devised in 1939 to meet the respirator problem that confronted the Northern Peninsula during the poliomyelitis epidemic. The Commission will also exhibit photographs of plastic surgery cases showing the highly successful results of surgical treatment available through the Commission. Charts and graphs of services and costs will also be displayed.

IV. Pinecrest Sanatorium, Powers, Michigan, and Michigan Tuberculosis Association

"A COMPARISON OF GASTRIC ASPIRATION WITH OTHER METHODS FOR DISCOVERY OF TUBERCLE BACILLI IN THE SPUTUM"

Exhibit presenting a study of 120 patients with a clinical diagnosis of pulmonary tuberculosis and negative routine slide examinations. An attempt to determine the relative value of laboratory procedures, i.e., the direct smear, concentrate of seven-day sputums and gastric aspiration in detecting Mycobacterium tuberculosis has been made.

V. Eloise Hospital and Infirmary, Eloise, Michigan

"DIAGNOSTIC METHODS IN TRICHINOSIS"

Exhibit illustrating the various laboratory diagnostic methods in trichinosis. The projection of live trichina larvae on the screen by means of a microvivarium will be demonstrated.

VI. Michigan Department of Health

"RAPID TREATMENT OF VENEREAL DISEASE"

The exhibit of the Bureau of Venereal Disease Control, Michigan Department of Health, will consist chiefly of photographs and illustrations of the Michigan Rapid Treatment Center, including facilities available, techniques of treatment used and posters outlining schedules of treatment and eligibility requirements for admission. A portion of the space may be devoted to the general V. D. Control Program.

VII. Michigan Department of Health

"SALMONELLA"

The salmonella exhibit will be designed to familiarize the medical profession with the more than 100 type specific enteric bacteria in the Salmonella group. It will consist of charts showing the type name and the antigenic structure of the many salmonellae. During the past year the Bureau of Laboratories of the Michigan Department of Health has made a Salmonella Typing Station available to the physicians of Michigan. The Bureau of Epidemiology of the Michigan Department of Health is prepared to give epidemiological service in relation to this whole group of paratyphoid organisms.

VIII. American Medical Association, Chicago

"DIETARY DEFICIENCY DISEASES"

The results of the various vitamin, protein, calcium and iron deficiencies are shown by means of colored transparencies. The contribution of selected servings of food to the daily requirements of the dietary essentials are depicted in graphic form. A pamphlet will be distributed.

IX. Wayne University College of Medicine, Detroit

"OPERATIVE MANAGEMENT OF TRAUMATIC INTRACRANIAL HEMORRHAGE"

A pictorial discussion of epidural, acute and chronic subdural, massive intracranial hemorrhage, and subdural collection of spinal fluid. Diagnostic criteria and operative technique will be shown by means of transparencies.

"STRAIN DIFFERENCES IN RESPONSE TO DIETHYLSTILBESTROL AND THE PRODUCTION OF BREAST CANCER IN THE RAT"

Significant differences were observed in the frequency of occurrence of pituitary adenomata, bladder papillomata, and calculi, and breast cancer in three inbred strains of rats following the implantation of pellets of diethylstilbestrol. Differences in mean adrenal and pituitary weights were observed eight weeks after daily graded injections of diethylstilbestrol in sesame oil.

X. Wayne University College of Medicine, Detroit

"THE TREATMENT OF THERMAL BURNS"

The exhibit on burns will be composed of posters and kodachrome transparencies. It is arranged to emphasize the four primary objectives of burn treatment, namely: (1) The prevention and treatment of shock; (2) the prevention or control of infection from the time of injury to the time of complete reepithelization of the burned area; (3) the maintenance of adequate nutrition; (4) the prevention of scars and contractures. A portion of the work shown is from the Henry Ford Hospital, Detroit.

MICHIGAN PATHOLOGICAL SOCIETY

The Michigan Pathological Society will meet in Grand Rapids on the occasion of the Annual Session of the Michigan State Medical Society.

The pathologists have arranged a program for Wednesday, September 27, in the Grill Room of the Pantlind Hotel, beginning with luncheon with the Section on Pathology at 12:00 noon. The scientific program will be presented between 2:00 and 4:00 p.m., in the Grill Room, followed by the MSMS discussion conference on pathology.

Dinner will be served at the Blodgett Memorial Hospital at 6:00 p.m. with the final meeting of the Society at 7:30 p.m., at the hospital.

M. O. Alexander, M.D., Blodgett Memorial Hospital, Grand Rapids, is in charge of arrangements.

—— Technical Exhibits ——

Abbott Laboratories **Booth E-6**
North Chicago, Illinois

Abbott representatives J. J. McBrady and D. E. Ziegenbein will be in attendance and will welcome exchanging notes with you regarding the wide variety of Abbott products on exhibit here.
A number of new items have been added since last we attended the Michigan State Medical meeting so be sure to view this display.

A. S. Aloe Company **Booth D-13**
St. Louis, Missouri

A. S. Aloe Company, Booth No. D-13, are showing a cross-section of their complete line of surgical and laboratory instruments and supplies. Featured will be American made stainless steel surgical instruments and such laboratory specialities as the Goth Kit for determination of sulfonamide concentration in blood and the new Somogyo Sugar Urine Comparator. Messrs. T. T. Boufford and H. J. Benedict, Aloe Michigan representatives, will be in charge of the booth.

The Baker Laboratories **Booth B-2**
Cleveland, Ohio

Physicians are cordially invited to see a demonstration of a time-saving method for feeding infants in the hospital and at home. Baker's Modified Milk, a modern, highly nutritious food for infants will be featured in the display. Melcose, a completely prepared milk, and Melodex (maltose and dextrin) will also be exhibited. Our representatives will be in attendance to welcome you and explain the special advantages of Baker's infant foods.

Bard-Parker Company, Inc. **Booth C-17**
Danbury, Connecticut

The following products will be exhibited at the Bard-Parker Booth No. C-17: Rib-Back Blades, Long Knife Handles for deep surgery, Renewable Edge Scissors, Formaldehyde Germicide and Instrument Containers, Transfer Forceps, Hematological Case for obtaining bedside blood samples.

Barry Allergy Laboratories, Inc. **Booth C-7**
Detroit, Michigan

Carpule intradermal and speedy scratch testing equipment will be featured and technique regarding their use explained. The co-ordination of skin test reactions and a history toward the preparation of desensitization material will be displayed and explained by Mr. A. W. Barry.

W. A. Baum Company, Inc. **Booth E-7**
New York, New York

The Lifetime KOMPAK and 300 MODEL Baumanometers cased in Duralumin as formerly and the STANDBY Model made of magnesium are again available. Increased production has resulted in the release of some of these critical metals for this use. All of these Models and a complete line of new replacement parts, will be on display in their Booth No. E-7.

Becton Dickinson & Company **Booth C-3**
Rutherford, New Jersey

Featured in Becton, Dickinson's booth will be the Yale-Lok Syringe and the Yale Rustless Needle with new Huber point, specially designed to penetrate smoothly without cutting tissue plugs and with minimum laceration of tissue—less seepage, less pain.

Ernst Bischoff Company, Inc. **Booth E-15**
Ivoryton, Connecticut

In our exhibit we shall feature Lobelin Bischoff, respiratory stimulant and resuscitant in asphyxia neonatorum; Anayodin, an effective, nontoxic amebacide; Diatussin and Diatussin Syrup, antispasmodic; Activin, a foreign protein for non-specific therapy; Viscysate, for the symptomatic relief of hypertension: Sas-Par, antipruritic, oral treatment for psoriasis.

The Borden Company **Booth C-8**
New York, New York



Visit Booth C-8 and learn about Borden's infant foods. Biolac in the new 13-ounce wartime tin . . . New Improved Dryco affording quicker solubility, lower cost, and increased vitamin potencies . . . Mull-Soy, the emulsified soy bean food for milk allergenic patients . . . Borden's Beta Lactose, nature's carbohydrate in an improved, readily soluble form . . . Also Klim and Merrell-Soule Powdered Milks.

Burroughs Wellcome & Co. (U.S.A.) Inc. **Booth C-22**
New York, New York



BURROUGHS WELLCOME & CO., New York, presents a representative group of fine chemicals and pharmaceutical preparations, together with new and important therapeutic agents of special interest to the medical profession.

Camel Cigarettes **Booths A-12, A-13**
New York, New York

CAMEL Cigarettes will exhibit large detailed photographs of equipment used in comparative tests of the five largest-selling brands of cigarettes. Representatives will be available to discuss research. Trans-Lux News will be supplied throughout the meeting.

Cameron Heartometer Company **Booth B-7**
Chicago, Illinois

THE CAMERON HEARTOMETER COMPANY is showing the improved Heartometer, a scientific precision instrument for accurately recording systolic and diastolic blood pressures. It also furnishes a permanent graphic record of the pulse rate, the nervous functioning of the heart, the myocardial response, as well as the functioning of the values. The Heartometer clearly reveals heart disturbances in both early and advanced stages and is of great value in checking the progress of medication and treatments.

Cameron Surgical Specialty Company **Booth C-5**
Chicago, Illinois

See the Cameron Flexible Gastroscopes and Cavicamera, the new Cameron Coagulo-Sigmoidoscope, Electro-Diagnostosets, Bronchoscopes-Esophagoscopes-Laryngoscopes, Binocular Prism Loupe, Mirrolite Magniscope and other new developments in electrically lighted Diagnostic and Operating Instruments. Cameron Electro-Surgical Units will also be on display.

Carnation Company **Booth E-9**
Milwaukee, Wisconsin



You are invited to visit the Carnation Company booth, No. E-9, where you will find presented some interesting information on the various uses of Irradiated Carnation Milk for infant feeding, child feeding and general diet purposes. Valuable literature will also be available for distribution.

Ciba Pharmaceutical Products, Inc. **Booth A-4**
Summit, New Jersey

Ciba invites you to visit its display at Booth No. A-4. Among the products displayed will be PRIVINE, as nasal vasconstrictor; METANDREN LINGUETS, a potent androgen for oral use; NUPERCAINE, a spinal anesthetic; VIOFORM, a non-irrating antiseptic and many others. Drop in and discuss these products with our representatives who will be ready to answer any question you may have.

The Coca-Cola Company **Booth A-11**
Atlanta, Georgia

Coca-Cola will be served to members with the compliments of the Coca-Cola Company.

Cottrell-Clarke, Inc. **Booth No. D-17**
Detroit, Michigan

To enable medical men in these busy war days to extend their services to more and more patients, Michigan's progressive case record house of Cottrell-Clarke, Inc., Detroit, are showing, not only the latest of their newer labor saving case record developments, but also various ideas in patients' appointment systems and other office procedure.

Cream of Wheat Corporation **Booth E-5**
Minneapolis, Minnesota

In booth No. E-5, both "Enriched 5-Minute" and "Regular" CREAM OF WHEAT will be on display. "ZING!," stabilized Wheat Germ, will also be available for inspection. It is an economical, high vitamin germ that has been specially stabilized to prevent rancidity.

Davis & Geck, Inc. **Booth A-8 and Cinema Room**
Brooklyn, New York

"This One Thing We Do"

Davis & Geck, Inc., will display its complete line of sterile surgical sutures, a comprehensive group unparalleled for meeting the rigid and varied requirements of leading surgeons in all fields. Among these are D&G Atraumatic sutures, Fine-Gauge catgut, Dermalon skin and tension sutures, a new line of products for use with Reese needles and many others. D&G products include every accepted material and approved size. As in previous years, a further feature of this exhibit will be a motion picture theatre in which a diversified and timely program of surgical films in full color will be presented daily. A representative from the laboratories will be in attendance at the booth and copies of the new D&G Suture Manual and other interesting booklets will be available. In charge—Frederick A. Geck.

DePuy Manufacturing Company **Booth E-14**
Warsaw, Indiana

Fracture Appliances and the Lambotte Fixateur—external fixation appliance for compound fractures of the long bones, will be explained by our representative, Mr. Chas. F. Klingel.

Detroit Creamery Company **Booth D-15**
Detroit, Michigan

The Sealtest display represents the milk and ice cream plants in Michigan affiliated with Sealtest, Inc., and National Dairy Products Corporation. Mr. Leonard, of the Arctic Ice Cream plant, Grand Rapids, and Mr. Fudge, of the Grand Rapids Creamery, will be in charge of the exhibit.

Dobo Chemical Corporation **Booth D-7**
New York, New York

The Auralgan Exhibit consists of a model of the human auricle four feet high together with a series of twenty-four three-dimensional ear drums, modeled under the supervision of outstanding otologists. Each of these drums depicts a different pathologic condition based upon actual case observation and prepared, in so far as possible, with strict scientific accuracy so as to be highly instructive and interesting to all physicians.

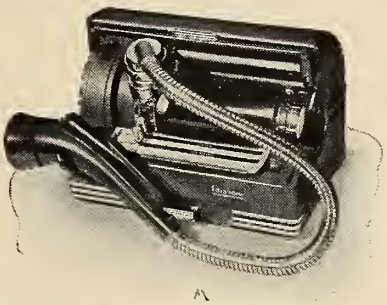
Duke Laboratories, Inc. **Booth A-10**
Stamford, Connecticut

At Booth A-10, Duke Laboratories, Inc., will have on display their stretchable, cotton-woven, adhesive-surface bandages and compresses, Elastoplast and Mediplast, used by practically every large defense plant in the country. There will also be on display Aquaphor, Nivea Creme, Nivea Skin Oil, Basis Soap and Tecto.

E & J Resuscitator Company **Booth No. D-4**
Detroit, Michigan

The E. & J. Resuscitator—Used in all cases of extreme shock, asphyxia, drownings, heart attacks, its application is simple. Instrument adjusts itself to any size lung, especially in the resuscitating of newborn, thereby eliminating the human element and saving precious moments in an emergency. This Resuscitator operates on a fixed pressure and the volumes are variable.

The Ediphone Company **Booth D-19**
Grand Rapids, Michigan



The Ediphone Company extends a cordial invitation to all physicians to visit the display of Ediphone equipment. See the new Edison Electronic Voicewriter, also Miracle Model Voicewriter, manufactured by Edison, who invented and perfected sound recording. Stop in for demonstration and to learn how we are helping the Medical Profession in this crisis.

Ethicon Suture Laboratories **Booth E-18**
New Brunswick, New Jersey

Tantalum wire sutures will be shown to physicians and surgeons visiting the Ethicon Suture Laboratories Exhibit.
Visitors at Booth E-18 will also be shown recent advances in nylon, cotton, gastro-intestinal, eye and cosmetic sutures.
Mr. M. C. Thompson will be in charge of the Booth.

C. B. Fleet Company, Inc. **Booth E-8**
Lynchburg, Virginia

This exhibit will feature Phospho-Soda (Fleet), which has been an ethical product for over half a century. This is a pure, stable, aqueous concentrate of the two U. S. P. sodium phosphates. It is indicated in hepatic and gallbladder dysfunctions and whenever a thorough eliminating action is desired. It possesses rapidity and mildness of action, with marked absence of nausea, griping or tenesmus.

General Electric X-Ray Corporation **Booth A-7**
Detroit-Lansing-Grand Rapids

We cordially invite the physicians and their families who attend this Annual Session to make use of the lounge facilities provided at our booth for their comfort. We particularly look forward to a visit from users of our equipment, and a cordial invitation is extended to all physicians who may have technical problems to discuss with our staff in attendance.

Gerber Products Company **Booth B-9**
Fremont, Michigan



Gerber's CEREAL FOOD and STRAINED OATMEAL are enriched and precooked. We invite your inspection of the literature and the display of the Gerber Foods.

Hanovia Chemical and Manufacturing Company **Booth D-9**
Newark, New Jersey

Hanovia Chemical and Manufacturing Company will exhibit a complete line of high-pressure self-lighting ultraviolet lamps for orificial and general body irradiation. A feature of the display will be the Hanovia Safe-T-Aire lamps for the destruction of air-borne bacteria. Our representatives will welcome your questions and interest in our product.

J. F. Hartz Company **Booths D-12, D-14**
Detroit, Michigan

The J. F. Hartz Company is looking forward to again meeting its friends at the 1944 Michigan State Medical Postgraduate Conference.
Our exhibit there will feature Hartz Laboratory controlled Pharmaceuticals as well as Physician and Hospital equipment and instruments.

H. J. Heinz Company **Booth D-20**
Pittsburgh, Pa.

H. J. Heinz Company wishes to acquaint you with 11th edition NUTRITIONAL CHART, NUTRITIONAL OBSERVATORY and SPECIAL DIETARY FOODS BOOK. Special feature—YOUR BABY'S DIARY and CALENDAR. Physicians practicing pediatrics and those prescribing soft diets will be especially interested in Heinz Strained and Junior Foods and our new Pre-Cooked Cereal Food.

Hoffman-La Roche, Inc. **Booth E-17**
Nutley, New Jersey

Pharmaceutical prescription specialities of rare quality, produced at Roche Park, where Vitamins are made by the ton, will be exhibited.
Syntropan, the antispasmodic that is replacing Belladonna, will be a featured product. The medical profession's interest in the many uses of the versatile Prostigmin and other scientific accomplishments will be satisfied by Hoffman-La Roche representatives who will be in attendance to discuss clinical problems.

Holland-Rantos, Inc. **Booth B-15**
New York, New York

A complete unit for contraceptive technique. Provides for patient comparison of Jelly and Cream. Contains, in a handsome case: Koromex diaphragm with special pouch; Koromex Trip Release Introducer (takes all sizes diaphragms); Tube Koromex Jelly (higher lubricating factor); Tube Koromex Cream (lower lubricating factor); Set Dickinson-Freret Fitting Charts.

G. A. Ingram Company **Booths C-2, C-4, C-6**
Detroit, Michigan

The G. A. Ingram Company of Detroit will exhibit a complete line of surgical instruments in both stainless steel and chrome, as well as all available electrical appliances. Their representatives will be more than pleased to have you call and obtain information on both new and old items.

"The 'Junket' Folks" **Booth B-13**
Little Falls, New York

In space B-13, "The 'Junket' Folks," Chr. Hansen's Laboratory, Inc. Enlarged photos illustrate the action of the rennet, enzyme in forming softer, finer milk curds. Free literature describes dietary uses of rennet-custards in infant, child, convalescent, or post-operative feeding. Home Economists, Faithe Williams and Thelia Bock on duty. Complimentary package of "Junket" Rennet Powder and "Junket" Rennet Tablets presented to physicians who register.

Kellogg Company **Booth E-10**
Battle Creek, Michigan



All Kellogg's ready-to-eat cereals contain valuable whole-grain nutrients. Corn Flakes and Rice Krispies, low fiber cereals, are indicated in wheat-free and low residue diets. All-Bran, containing only 8% actual fiber, contributes Vitamin B_1, iron, and niacin to the diet.
Kellogg's Pep whole wheat flakes is fortified with additional vitamins B_1 and D.

A. Kuhlman & Company **Booth D-8**
Detroit, Michigan

A. Kuhlman & Co. will exhibit American Cystoscope Makers' cystoscopes and urological instruments and supplies, also C. R. Bard & Co.'s Bardex and Bardam catheters, etc., and a selected line of American-made surgical instruments. The exhibit will be in charge of Henry A. Kuhlman.

Lea & Febiger **Booth C-10**
Philadelphia, Pennsylvania

At Booth C-10 Lea & Febiger will exhibit among their new works, Babcock's "Principles and Practice of Surgery," Donaldson's "Surgical Disorders of the Chest," Lewin on Bachache and Sciatica and new editions of Spaeth's "Ophthalmic Surgery," Rowe's "Elimination Diets and the Patient's Allergies," Simmons and Gentzkow's "Laboratory Methods of the United States Army," Bell's "Textbook of Pathology," Rhinehart's "Roentgenographic Technique," Craig and Faust's "Clinical Parasitology," Kraines' "Therapy of the Neuroses and Psychoses," Ballenger on the Nose, Throat and Ear, Ballenger's Manual, Boyd's "Textbook of Pathology," Ormsby and Montgomery on Diseases of the Skin, Levinson and MacFate's "Clinical Laboratory Diagnosis" and Gray's Anatomy.

Lederle Laboratories, Inc. **Booth E-1**
New York, New York

At the Lederle Laboratories, Inc., exhibit, Michigan representatives of the organization will welcome their many Michigan medical friends. They will show their general biological and pharmaceutical line with special emphasis on Penicillin and Sulfonamide products.

Libby, McNeill & Libby **Booth D-22**
Chicago, Illinois

Libby's Strained and Homogenized Baby Foods are featured at the Libby booth. Physicians are invited to stop and discuss new findings on the greater availability of iron and ease of digestion of Libby's Council-accepted foods for babies.

Eli Lilly and Company **Booth A-1**
Indianapolis, Indiana

The Lilly exhibit will feature an anatomical model illustrating the techniques of caudal and spinal anesthesia. Lilly products will be on display, and medical service representatives will be present to assist visiting physicians in every possible way.

J. B. Lippincott Company **Booth A-6**
Philadelphia, Pennsylvania

Showing the complete list of LIPPINCOTT SELECTED PROFESSIONAL BOOKS, with many new titles and new editions of old favorites, and the ever-new LIPPINCOTT JOURNALS. New items of special interest include—Bunnell: SURGERY OF THE HAND; Simmons-Wayne: GLOBAL EPIDEMIOLOGY; the American Edition of Fry: THE DENTAL TREATMENT OF MAXILLO-FACIAL INJURIES; Brown-McDowell: SKIN GRAFTING OF BURNS; Heuer: TREATMENT OF PEPTIC ULCER; Barach: PRINCIPLES AND PRACTICE OF INHALATIONAL THERAPY; Hotchkiss: FERTILITY IN MEN, and Siegler: FERTILITY IN WOMEN, and the new Twelfth Edition of LIPPINCOTT'S QUICK REFERENCE BOOK OF MEDICINE AND SURGERY.

The Liquid Carbonic Corporation **Booth D-5**
Wall Chemicals Division
Detroit, Michigan

The Medical Gas Division of the Liquid Carbonic Corporation will feature in their exhibit the following medical gases in various size cylinders: nitrous-oxide, medical oxygen, ethylene, cyclopropane, carbon-dioxide, carbon dioxide-oxygen mixtures, etc., together with equipment for administering the same. Our representatives in attendance will be Mr. J. J. Esop and Mr. E. G. Madole.

M & R Dietetic Laboratories, Inc. **Booth C-19**
Columbus, Ohio

M & R Dietetic Laboratories, booth No. C-19, will display Similac, a food for infants deprived either partially or entirely of breast milk; also powdered SofKurd. H. Behncke and L. A. MacDonald will appreciate the opportunity to discuss the merit and suggested application of these products.

McKesson Appliance Co. **Booth E-16**
Toledo, Ohio

The McKesson Appliance Company invites you to come to its booth with your service problems. During the present emergency we advise careful upkeep of all your equipment, and if we can be of any help to you, do not hesitate to call upon us. We will display our equipment as usual.

McNeil Laboratories, Inc. **Booth E-20**
Philadelphia, Pennsylvania

All members and guests of the Michigan State Medical Society are cordially invited to visit the McNeil Laboratories Booth No. E-20. In attendance will be trained representatives to describe interesting facts about Digitalis Duo-test and other outstanding products of McNeil research.

Mead Johnson & Company **Booths B-10, B-12**
Evansville, Indiana

Servamus Fidem, means We Are Keeping the Faith. Almost every physician thinks of Mead Johnson & Company as the maker of Dextri-Maltose, Pablum, Oleum Percomorphum, and other infant diet materials—including the new pre-cooked oatmeal cereal, Pabena. But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to Booths Nos. B-10 and B-12 will be time well spent.

Medical Arts Surgical Supply Company **Booths**
Grand Rapids, Michigan **C-9, C-11, C-12, C-14**

The Medical Arts Surgical Supply Company of Grand Rapids will show in their exhibit the latest in medical furniture, short wave equipment, surgical pumps and surgical instruments. Those in attendance will be S. L. Lepard, M. J. Allen, R. V. Oosting, Ed Williams, George Klaver, and Harold Hadden.
In addition to this they will occupy a space showing their latest in laboratory items.

Medical Case History Bureau **Booth A-14**
New York, New York

Representatives will demonstrate **patient's history record charts** for general practice and all specialties; also **simple and efficient bookkeeping cards.** Of special interest is the unique method by which interesting cases may be cross-indexed according to the disease, directly on the patient's history chart.
A few minutes spent in this booth may prove to be a great timesaver in your office record system.

Medical Film Guild **Booth A-16 and Cinema Room**
New York, New York

Medical Film Guild emphasizes its talking papers in this year's program of "MEDICAL FILMS THAT TEACH." Hospital and Medical Society program chairmen, now faced with depleted staffs because of the war emergency, who desire educational material for their meetings, find that Medical Film Guild's motion picture film textbooks answer that important problem. Through grants for postgraduate instruction, these films are available at no charge to any hospital or medical society meeting and to the medical services connected with the Armed Forces of the United States. Exhibition is also included at no charge under this plan. Subjects available are: INGUINAL HERNIOPLASTY, ASPHYXIA NEONATORUM, NONOPERATIVE TREATMENT OF PARANASAL SINUSITIS, OTITIS MEDIA IN PEDIATRICS, A CLINIC ON ACUTE MASTOIDITIS, OTOSCOPY IN THE INFLAMMATIONS, A CLINIC ON SIGMOID SINUS THROMBOSIS, A CLINIC ON PETROSITIS WITH MENINGITIS, PHARMACOLOGY OF RESPIRATORY STIMULANTS, AMEBIASIS AND ITS TREATMENT, A CLINIC ON OTITIC PURULENCIES.

Medical Protective Company **Booth C-20**
Fort Wayne, Indiana

The most exacting requirements of adequate liability protection are those of the professional liability field. The Medical Protective Company, specialists in providing protection for professional men, invites you to confer, at their exhibit, with the representative there. He is thoroughly trained in Professional Liability underwriting.

Mellin's Food Company **Booth E-13**
Boston, Massachusetts

The Annual Session of the Michigan State Medical Society affords an opportunity for the exchange of ideas and opinions relative to the feeding of infants and in regard to the preparation of nourishment for adults requiring restricted diet. Representatives of the Mellin's Food Company will be pleased to discuss the subject.

Merck & Co., Inc. **Booth B-17**
Rahway, New Jersey

Physicians attending the 79th Annual Session of the Michigan State Medical Society are cordially invited to visit the Merck booth. Literature will be available on Merck Medicinal Specialties and also on penicillin, the vitamins, and the sulfonamides. If you are interested in an inhalation anesthetic for short operative procedures, ask about Vinethene. It produces rapid induction of anesthesia and rapid, complete recovery with infrequent nausea or vomiting.

The Wm. S. Merrell Company **Booth E-2**
Cincinnati, Ohio

MERRELL
Since 1828

Members and guests are invited to stop for a copy of the interesting and instructive booklet, "Can Oral Vaccines Protect Against the Common Cold?" presenting a review of published reports on both sides of this timely question. Well-known Merrell prescription specialties will also be on display at the booth.

Michigan Medical Service **Booth E-22**
Detroit, Michigan

Charts of progress of MMS for the past twelve months and total of four years of operation. Premiere showing of black ink on ledger. Description of possibilities for further extension of service. Description of handling of service reports received from doctors.

C. V. Mosby Company **Booth B-11**
St. Louis, Missouri

New books and new editions to be displayed by the C. V. Mosby Company will include Dodson "Urological Surgery," Meakins "Practice of Medicine," Selling "Synopsis of Neuropsychiatry," Kuhn "Industrial Ophthalmology," Herrmann "Synopsis of Diseases of the Heart and Arteries." Titus "Management of Obstetric Difficulties," and Davison "Synopsis of Materia Medica, Toxicology and Pharmacology." Mr. Arthur Garbruck will be in attendance and glad to discuss your book needs with you.

National Live Stock and Meat Board **Booth E-19**
Chicago, Illinois

A charming, illustrated nutrition book for children, entitled **You and Your Engine,** has just been published by the National Live Stock and Meat Board and is ready for distribution. This book, plus a new set of charts in full color, the Nutrition Yardstick and other educational literature, will be displayed in Booth No. E-19.

Ortho Products, Inc. **Booth D-11**
Linden, New Jersey

Ortho's exhibit will feature their council-approved products for the control of conception. Booklets, reprints, etc., will be distributed, dealing with various methods. Ask for the recently-published, "Studies in Human Fertility," a scientific digest dealing with the many aspects of fertility control.

Pet Milk Company **Booths C-16, C-18**
St. Louis, Missouri



A complete display of material illustrating the timesaving Pet Milk services available to physicians. Specially-trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit.

Parke, Davis & Company **Booths D-1, D-3**
Detroit, Michigan

You will find displayed at the PARKE-DAVIS BOOTH many outstanding Pharmaceuticals and Biologicals. Included in this Technical Exhibit are such noteworthy products as PHEMEROL, a new type of germicide and antiseptic; ADRENALIN PREPARATIONS; MAPHARSEN; THEELIN; DESPECIATED ANTITOXINS; also other therapeutic agents of current interest. You are cordially invited to visit this Exhibit.

Philip Morris & Co. Ltd., Inc. **Booth B-8**
New York, New York



Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

Picker X-Ray Corporation **Booth D-2**
New York, New York

Picker X-Ray Corporation will show the U. S. Army Field Unit. This unit has been dropped by parachute and also has been floated ashore for use in remote theatres of the present World War.
Picker will also show a complete line of x-ray accessories.

Pitman-Moore Company **Booth E-12**
Indianapolis, Indiana

The Pitman-Moore exhibit will feature a variety of pharmaceutical and biological products, including a number which are seasonable during the fall and early winter. Detail men from the Michigan area and personnel from the research and production laboratories will be on hand to answer questions.

Procter & Gamble Company **Booth C-13**
Cincinnati, Ohio



The makers of Ivory Soap, Procter & Gamble, will occupy Booth C-13. You are invited to stop at the exhibit and receive a free sample of Ivory Soap, a copy of the booklet "The Story of Soap," and a reprint of an article "Tests for Mildness of Soap."
Also, Procter & Gamble will be glad to supply you with a quantity of the booklet "Bathing Your Baby —The Right Way," which is proving to be a time-saver for doctors and nurses, and a real help to new mothers.

Professional Management **Booth D-6**
Battle Creek, Michigan

"A Complete Business Service For The Medical Profession." Eleven years of service to Michigan Doctors featuring **business counsel, tax advice** and planning of **record systems.**

Radium Emanation Corporation **Booth E-3**
New York, New York

The Radium Emanation Corporation (Booth E-3) will display Removable and Permanent Radon Seeds, implanters and other up-to-the-minute Radon and Radium applicators for Cancer-therapy. The new Ametal Rubber Inverted T-tube and improved Pessary (Regaud technique in Cervix Carcinoma), and the new nasopharyngeal applicators will be demonstrated.

Randolph Surgical Supply Company **Booth A-9**
Detroit, Michigan

Randolph Surgical will again display unusual and distinctive equipment, as manufactured by the countries' leading manufacturers—our representatives who will be happy to serve you will be—Ted Ward, J. J. Mueller, and Cliff Randolph.

Riedel-de Haen, Inc. **Booth E-11**
New York, New York

The Riedel-de Haen, Inc., exhibit at booth No. E-11 will display Decholin, a hydrocholeretic, Degalol, a choleretic, and Cholmodin, a laxative agent. Physicians are cordially invited to discuss with our representatives the wide therapeutic applications of these chemically-pure bile acid products.

W. B. Saunders Company **Booth A-2**
Philadelphia, Pennsylvania

This publishing house will exhibit their complete line of books. Included among the new and important books to be shown are: Bockus' 3-volume work on "Gastro-enterology," 5th edition of Christopher's "Minor Surgery," Erich & Austin's "Traumatic Injuries of Facial Bones," Hoffman's "Female Endocrinology," Moll's "Aesculapius in Latin America," Orr's 1-volume "Operations in General Surgery," Pullen's "Medical Diagnosis," the (20th) edition of the illustrated Medical Dictionary, new (3rd) edition of Stokes' "Syphilology," 1944 Mayo Clinic Volume, Lundy's "Anesthesia," Wharton's "Gynecology and Female Urology," the Military Medical and Surgical Manuals, Official U. S. Public Health Service Industrial Hygiene Manual, Stieglitz' "Geriatrics," Weiss & English's "Psychosomatic Medicine," and many others.

Schenley Laboratories, Inc. **Booth D-10**
Lawrenceburg, Indiana

Schenley Laboratories, Inc., will show an interesting and informative exhibit portraying the clinical indications and administration of Penicillin **Schenley.** Included are color photographs of patients successfully treated. A series of pictures illustrates the manufacture, standardization, and testing of Penicillin **Schenley** at the Laboratories at Lawrenceburg, Indiana.

Schering Corporation **Booth E-21**
Bloomfield, New Jersey

Schering Corporation, in line with their policy of bringing out the latest in endocrine research, is featuring the new estrogenic product—ESTINYL Tablets.
ESTINYL, a derivative of the natural hormone alpha-estradiol, is most economical and is orally effective in dosage of .02 and .05 mg. It produces very little nausea and toxic side effects. Other Schering preparations on display will be ORETON-F Pellets, ORETON, ORETON-M Tablets, PROGYNON-B, PRANONE, PROLUTON, and CORTATE, and the diagnostic products for X-ray—NEO-IOPAX and PRIODAX.

G. D. Searle & Company **Booth A-3**
Chicago, Illinois



G. D. Searle & Co. will show a number of the new products of Searle Research which has contributed so much to the recent armamentarium of the physician. Products such as Searle Aminophyllin, Metamucil, Ketochol, Furmerane, Floraquin, Gonadophysin, Tetrathione, and Pavatrine are results of this research which has been greatly expanded in the new Searle Research Laboratories.
An illustration of the new Laboratories will be features in the exhibit.

Scientific Sugars Company **Booth C-1**
Columbus, Indiana

Scientific Sugars Co., Booth No. C-1, will display Cartose, Hidex and the Kinney line of nutritional products. The company representatives will be in attendance for the purpose of serving the physicians that stop at the booth.

Sharp & Dohme, Inc. **Booth D-21**
Philadelphia, Pennsylvania

Sharp & Dohme will have their display at Booth No. D-21 featuring their new sulfonamide, "Sulfamerazine," and also "Sulfasuxidine," "Lyovac" Normal Human Plasma, Tyrothricin Concentrate for human use, "Depropanex," "Delvinal" Sodium, "Propadrine" Hydrochloride products and "Lyovac" Tetanus Antitoxin Bovine. Our representatives, Messrs. R. L. Moser, A. C. Edmunds and R. K. Fiddes, will be on hand to welcome all visitors and furnish information on Sharp & Dohme products.

Smith, Kline & French Laboratories **Booth E-4**
Philadelphia, Pennsylvania

Benzedrine Sulfate Tablets and Pragmatar are featured at this exhibit.
The potent central nervous stimulation of benzedrine sulfate offers, throughout a wide range of application, "a therapeutic rationale which, in its very efficiency, cuts across the old categories."
Pragmatar—a significant improvement in tar-sulfur-salicylic acid ointments—is highly effective in an unusually wide range of common skin disorders, including subacute and chronic eczemas; subacute and chronic fungous infections; psoriasis; seborrheic affections; pityriasis rosea; etc.
Our especially-trained professional representatives will be glad to discuss with you the potentialities and possible indications of our products in your own practice.

Spencer Incorporated **Booth C-15**
New Haven, Connecticut

You are cordially invited to visit our exhibit, featuring individually-designed support for abdomen. back and breasts. Doctors will be especially interested in the scientific service for patients who have undergone mastectomy, and in the spinal support as an aid to treatment of ruptured disc and other back de-rangements. Supports for hernia, visceroptosis with symptoms, postoperative, obesity, maternity and post-partem are also on display.

E. R. Squibb & Sons **Booth B-4**
New York, New York

Physicians attending the Michigan State Medical Society meeting are cordially invited to visit the Squibb Exhibit, Booth No. B-4. Several new items will be shown. Among them is intocostrin, the standardized Purified Curare Extract now widely used to soften convulsion in shock therapy; a new, highly useful therapeutic multi-vitamin preparation; a sulfathiazole-ephedrine-derivative combination for ophthalmic use. Information on new products useful in venereal disease therapy and control will also be available.

Frederick Stearns & Company **Booths B-3, B-5**
Detroit, Michigan

Doctors are cordially invited to visit our attractive convention booth to view and discuss outstanding contributions to medical science developed in the Scientific Laboratories of Frederick Stearns & Company.
Our professional representatives will be pleased to supply all possible information on the use of such outstanding products as Neo-Synephrine Hydrochloride for intranasal and ophthalmologic use, Neo-Synephrine Sulfathiazolate, Amino Acids (Parenamine) for parenteral and protein feeding, Mucilose for bulk and lubrication, Fergon (Ferrous Gluconate), Gastric Mucin, Susto, Trimax, Appella Apple Powder, Nebulator with Nebulin A, and our complete line of Vitamin products.

William R. Warner & Co., Inc. **Booths D-16, D-18**
New York, New York

William R. Warner & Co., Inc., will exhibit its extensive line of specialty pharmaceuticals, including several new preparations of interest to physicians engaged in general and specialized practice.

Westinghouse Electric & Manufacturing Co.
Pittsburgh, Pennsylvania **Booth A-15**

Westinghouse Electric & Manufacturing Company will exhibit an eight-section illuminator, in which will be mounted translight illustrations of the latest equipment for fluorescopy and radiography. No physical exhibit of actual equipment will be made but Westinghouse x-ray application engineers will be in attendance to discuss present and postwar equipment problems.

White Laboratories, Inc. **Booth B-6**
Newark, New Jersey

At the White Laboratories, Inc., booth No. B-6, you will find complete information regarding White's Sulfathiazole Gum—one of the latest developments in the field of oropharyngeal chemotherapy.
White's "Diagnostic Aids to Vitamin Deficiency States" will also be available.
Review the latest clinical reports on the results of the use of White's Vitamin A and D Ointment in the treatment of burns, abrasions and indolent ulcers. This is a product which you will undoubtedly find of great interest.

Winthrop Chemical Co., Inc. **Booth B-1**
New York, New York

Winthrop Chemical Company, Inc. has available a number of interesting and highly-informative booklets; ask particularly for your copy of Penicillin and Annotated Bibliography.

Wyeth Incorporated **Booths B-14, B-16, B-18, B-20**
Philadelphia, Pennsylvania
Bovinine Company **Petrogalar Laboratories**
Reichel Laboratories **S. M. A. Corporation**
John Wyeth & Brother

The Wyeth display will graphically illustrate allergy and peptic ulcer diagnosis, treatment of constipation, and a new method of evaluating the physical fitness of the adolescent.
Pharmaceutical, biological, and nutritional representatives will be in attendance.

Zimmer Manufacturing Company **BoothA-5**
Warsaw, Indiana

The Zimmer Manufacturing Company will exhibit a full line of splints and bone instruments. The Corbett Finger and Thumb Splints, and also the new Stryker Screw Driver will be featured among the new items on display. Complete demonstrations of the Zimmer Reduction-Retention Apparatus will be given upon request, and pictures showing the results of its use will be on display.

Be Sure to Visit EVERY BOOTH

There Is Much That Is New and Interesting

To our business friends in the Technical Exhibit, the Michigan State Medical Society expresses sincere thanks for their splendid cooperation and very tangible contribution to the great success of the 1944 Conference.

ANNUAL REPORT OF THE COUNCIL—1943-44

The Council met three times and the Executive Committee met nine times (up to September 24, 1944), a total of twelve meetings since last September's Annual Session of the State Society. As in the past, all the business of the Society—including matters studied and recommendations made by its twenty-eight Committees—was referred routinely to The Council or to its Executive Committee for consideration, approval, and action.

Membership

Members of the State Society as of July 31 and as of December 31, from 1935 to 1944, are indicated in the following chart:

	1944	1943	1941	1939	1937	1935
7/31	4,715	4,661	4,403	4,255	3,757	3,410
12/31		4,786	4,621	4,425	3,963	3,653

The figures for 1944 include 3,522 Active Members, 51 Emeritus and Retired Members, and 1,142 Military Members. Members in military service are accorded full membership privileges in the State Society and their dues are remitted.

Finances

At the meeting in September, 1943, of the Michigan State Medical Society House of Delegates, a $10.00 assessment was levied to create a public relations fund. All of the money so collected has been held for that purpose and a detailed account of all expenditures will be made in a separate report.

The usual audit by Ernst & Ernst for the fiscal year was made. They made some suggestions and concluded that as a whole the Society was in a sound financial condition, and was being well managed.

We must expect a further curtailment of funds because still more of our members are leaving for the armed services.

The Council believes that a great deal of the credit for the sound investments should go to the Treasurer. Any member interested in a detailed report of the finances will be welcomed at the headquarters, 2020 Olds Tower, Lansing, Michigan.

The Journal

Some changes have been made in the personnel of the Publication Committee during the past year due in part to the resignation of the chairman, Roy C. Perkins, M.D., who had proved to be a very capable leader in the publication of The Journal. It is with regret we have to note his retirement from this assignment of The Council.

Wilfred Haughey, M.D., has done exceptionally fine work as Editor despite many handicaps incident to wartime shortages. It has been necessary to reduce sharply the number of pages of The Journal, but at no time has the high quality of the contained material been sacrificed. For the first time, The Journal has become self-sustaining, the result of careful business management. Every effort has been made to send this publication to the members of the Michigan State Medical Society in the armed forces, and it has been done in all cases except where a permanent address is not known.

Advertising matter has regularly been accepted through the Coöperative Medical Advertising Bureau of the American Medical Association which furnishes only advertisements of such products as are approved by the American Medical Association Councils. It was felt by the Publication Committee that advertisements could well be accepted of products manufactured by reliable firms which are recognized as valuable therapeutic agents, and used by many physicians, but which for some reason or other are not as yet Council-accepted, and such a policy was adopted with the result that our volume of advertising has greatly increased. In practically all instances advertising companies have been very careful not to make extravagant claims of therapeutic value and to avoid price quotations. All material submitted for our advertising pages is carefully scrutinized by the Publication Committee, or by the members of the Executive Committee of The Council.

It is the desire and aim of the Publication Committee to furnish the profession through the pages of the Journal all available information concerning trends in medical practice, and to take leadership in its Editorial columns to point out a policy which seems best for our membership to pursue, bearing ever in mind a desire to maintain a high standard of publication, and to encourage always the giving of intelligent and efficient service by the profession to the public.

R. S. Morrish, M.D.

County Societies

By extraordinary effort our civilian physicians are supplying the medical needs of the people of our state. There are no widespread complaints of lack of medical care in Michigan. Our medical and hospital care plans have contributed materially to a satisfaction and appreciation of the medical services supplied by our profession.

Newspaper and radio reports continuously praise the services of our military members. We note with great pride that our civilian doctors were able to fit into the military picture, and by their combined efforts materially reduce war mortality and produce the best medical care that any army in the world has ever received.

We are facing a legislative year with fewer friends in the legislative halls. Self-centered interest of the individual physician in his practice and his lackadaisical attitude toward problems and trends which may affect the whole future of medicine is throwing a tremendous burden upon the shoulders of the officers of our state society. The individual physician must be made to realize that these problems are of primary importance in his endeavors. In his hands lies the total responsibility for the future of the practice of medicine. Our military members have sacrificed their practices and are risking their lives to fight for us who have remained at home. Our civilian members must be alert and make every effort to maintain the practice of medicine according to the American way for our military members. We must not let them down—our task is a big one and must be assumed by each and every doctor of medicine.

Organizations

Despite wartime conditions, organization in 54 of the 55 county medical societies continued in excellent condition. The one odd county which has experienced some dissension has referred its problems to the MSMS Ethics Committee for investigation, and it is hoped, by the time the House of Delegates meets in September, this current problem shall have been solved.

The County Secretaries Conference of January 30, 1944, in Detroit was a "School of Information" on federalization, regimentation, and bureaucracy. It was the most enthusiastic and best attended Conference in the history of the Society.

Nine Secretary's Letters were mailed during the year, six to all members of the Society and three to Presidents, Secretaries and Editors of County Societies.

AMA Delegates.—As in the past, the Executive Committee of The Council held a meeting with Michigan's Delegates to the AMA House of Delegates on May 24, 1944, and discussed a number of important economic and sociologic matters which subsequently were on the agenda of the Chicago meeting of June 12-13.

Committees

Most of the State Society Committees continue to be very active, despite wartime demands on the time of committee members. We invite your consideration of the annual reports of these productive groups, published in the Delegates' Handbook and in The Journal.

Scientific Work.—the 1944 Annual Session with an excellent scientific program is best evidence of the many months of work of the Committee on Scientific Work.

Postgraduate Medical Education.—The Committee on Postgraduate Medical Education continues to offer to Michigan physicians a high quality program in postgraduate work. In addition, the Postgraduate Extension Committee specifically recommends that doctors of medicine and laymen interested in sound medical service and education contribute during their life and in their wills to the MSMS Foundation for Postgraduate Medical Education.

The Public Relations Committee assumed a major task in 1944 by inaugurating a radio program over 12 stations, by sponsoring lay and professional speakers before many groups, by issuing thousands of pamphlets re bureaucracy and federal regimentation, and by cooperating with other groups interested in preserving the American way of life.

The Cancer Committee completed its "Cancer Manual" and distributed it to all members of the Michigan State Medical Society. This represented a monumental labor, accomplished by tact and hard work.

The Industrial Health Committee presented its very successful second Annual Postgraduate Industrial Conference on April 6 in Detroit.

The Radio Committee instituted a series of scientific presentations over WJR, through the coöperation of the U. of M. Extension Division. Much good results from this type of public education.

All committees functioned well. Sincere thanks are extended to our committee chairmen and members for outstanding services performed in behalf of all members of the State Society during the past year.

Contacts With Governmental Agencies

EMIC Program.—This matter, referred by the 1943 House of Delegates to The Council, was the basis of much discussion at every meeting of The Council and of its Executive Committee and resulted in a series of meetings with representatives of the U. S. Children's Bureau, the Michigan Department of Health, Michigan Medical Service, and with the Auditor General of Michigan. The MSMS Council met with Edwin F. Daily, M.D., of the U. S. Children's Bureau on September 23; the Special Committee on EMIC Program met with Martha M. Eliot, M.D., of the U. S. Children's Bureau and Peter Seitz (of the Solicitor's Office attached to the Bureau) in Detroit on June 8. Two presentations were made: (a) that allotments for the EMIC program be made direct to the serviceman's wife and dependents; (b) that payment in this state be made through Michigan Medical Service. Both of these recommendations were turned down, despite the desires of the entire medical profession as expressed in a poll taken by the Special Committee (Drs. Ledwidge-Keyport-Foster) in October. The blunt refusal to date of executives of the U. S. Children's Bureau to amend the Michigan plan in any way represents a perfect example of autocracy by bureaucracy.

During negotiations, it was recommended that, so far as the State Society is concerned, physicians may properly:

(a) Sign the blanks to provide for hospital service, giving professional care gratis; or

(b) Sign the blanks and accept the government fee for medical care; or

(c) Decline to participate in the program, as physicians see fit.

In May, Congressman A. L. Miller of Nebraska introduced into Congress H.R. 4663 to transfer all health activities in the U. S. Department of Labor to the USPHS. The Executive Committee commended Dr. Miller on the introduction of this bill. A recommendation on this matter follows.

Advisory Committee on EMIC Program. The new State Commissioner of Health, William DeKleine, M.D., appointed an Advisory Committee on the EMIC Program to counsel his Department in connection with this troublesome slice of bureaucracy. He graciously appointed on this Committee Drs. Ledwidge, Keyport and Foster, to represent the Michigan State Medical Society.

Michigan Crippled Children Commission.—Excellent relations continue to exist between the State Society and the Commission.

"Institute on Public Health Economics."—The 1943 MSMS House of Delegates adopted a resolution on this "Institute" which inaugurated the opening of the new administration building of the School of Public Health at Ann Arbor. Subsequent correspondence with the Dean of the School of Public Health at the University of Michigan elicited no satisfactory results. So the matter was finally discussed with Dr. Alexander G. Ruthven, President of the University of Michigan, on June 1. It is hoped that this meeting will lead to better understanding between these groups.

Contacts With Nongovernmental Agencies

Michigan Medical Service.—Annual Reports and statistical data on this corporation will be presented to the members of the House of Delegates, as members of Michigan Medical Service, at the Annual Meeting of MMS in Grand Rapids on Tuesday, September 26.

The resolution, presented to the 1943 House of Delegates, urging that only Doctors of Medicine be recompensed by Michigan Medical Service for services performed to subscribers, was referred to a Special Committee (Drs. Sladek-Beck-Riley-Witwer) which recommended to The Council in January that no action be taken until such time as all indebtedness of Michigan Medical Service is liquidated.

Michigan Hospital Service vs. Pathologists.—The complaint of the pathologists of the state that this corporation was encouraging hospitals to practice medicine by inserting in its inter-hospital agency contract a provision that would make all pathologists the servants of hospitals, was the basis for discussions with Michigan Hospital Service which led to an arrangement, satisfactory to all concerned, whereby pathologists receive their remuneration, as individual practitioners of medicine, not from the hospitals but from the agency of their own creation, Michigan Medical Service, for pathological service rendered subscribers of Michigan Hospital Service.

Michigan Health Council.—This Council, composed of representatives of the MSMS, the Michigan Hospital Association, Michigan Medical Service, and Michigan Hospital Service, is a vehicle whereby the member organizations can coördinate their efforts in arranging for the availability of medical, hospital, and related services, and informing the public through a general educational program what these organizations are doing to meet the health needs of all people in the state. The first project of the Michigan Health Council is a survey of public opinion, the results of which will be presented to the members of the MSMS at the Sixth General Assembly of the Annual Session, Thursday evening, September 28, 1944, in Grand Rapids. The future program of the Michigan Health Council will be based upon facts gathered from the people themselves through this survey.

Other Matters Referred to The Council by 1943 House of Delegates

1. The resolution to establish an American Medical Association office in Washington, D. C., was referred to a Special Committee of The Council which notified all state societies concerning this action of the MSMS House of Delegates and of the urgent need for the creation of such a bureau of information in the national capital.

The AMA Council on Medical Service opened the Washington, D. C., office on April 3, 1944.

2. The notification of the resolution to change the structure of the American Medical Association, as approved by the 1943 House of Delegates, was also sent to all other state medical societies prior to the 1944 meeting of the AMA House of Delegates. The Michigan Delegates introduced this resolution into the AMA House of Delegates on June 12. Report on the action of the AMA is contained in the Annual Report of Michigan's Delegates to the AMA.

3. Special Assessment. The $10 assessment, levied on all members by the 1943 MSMS House of Delegates, was kept separate and distinct from the general MSMS fund and was known as the "public educational account." A separate accounting was made monthly to The Council or its Executive Committee, and will be presented to the House of Delegates by The Council in its supplemental report on September 25. Briefly, the money was allocated for radio presentations, lay speakers, purchase and distribution of pamphlets, and contributions to Michigan Health Council for its survey of public opinion.

4. Declaration of Medical Policies. The display card pledging nonsupport of a state medical bureaucracy, and the blank to be signed pledging nonacceptance of medical regimentation, were distributed to county medical societies in Michigan on two occasions; the latter also was included in the program of the April 6th Industrial Medical and Surgical Conference. In addition, all other state medical societies were sent this material.

Miscellaneous

(a) During the past year, the Early House on Mackinac Island, the scene of Beaumont's first experiments, was purchased through the generosity of Parke, Davis & Company and presented to the Michigan Mackinac Island Commission which plans to restore it to its original form and dedicate it as a permanent medical museum.

(b) Physical Medicine. Before the announcement of the Baruch award of $1,100,000 to encourage Physical Medicine, the MSMS Executive Committee of The Council had communicated with the Deans of the medical schools in Michigan urging them to stress the importance of Physical Medicine in their curricula; also, it secured Frank H. Krusen, M.D., now Director of the Baruch Committee, to appear on the General Assembly program in Grand Rapids on September 28, 1944.

(c) Michigan Doctors of Medicine in military service reach the startlingly high total of 2,175. Their names were published in the Military Members' Number of the MSMS *Journal* (March, 1944). May God bless and protect them.

Recommendations

The Council recommends:

1. That County Medical Societies, their officers and individual members contact in person or by letter our U. S. Senators and Congressmen from Michigan urging that they give favorable consideration to H.R. 4663, introduced into the House of Representatives by Congressman A. L. Miller of Nebraska on April 25, which would transfer all health activities of the U. S. Department of Labor to the USPHS; further, that they consider the establishment of a Department of Health in the federal government, to be headed by a Secretary of Health (who shall be a Doctor of Medicine) as a member of the Cabinet.

2. That the House of Delegates consider the following suggestion as a means of saving vital paper stock and considerable expense: that, as in the past, a complete stenographic report of every resolution, motion and word spoken during the House of Delegates session be transcribed and retained in the permament archives of the Society, available for study by any member of the State Society at any time, but that the House of Delegates Transactions as published in the MSMS *Journal* be condensed.

3. That the House of Delegates reaffirm its authorization to The Council either to levy a capital assessment or assessments, not to exceed a total of five dollars, or to increase the dues of the State Society for the calendar year 1945 by a sum not to exceed five dollars, in addition to the present annual dues, to meet the ordinary expenses of the Society as seems justified in the Council's considered opinion.

(It is to be noted that this request of The Council was granted by the House of Delegates in 1938-1939-1940-1941-1942 but was never invoked. The request for the five-dollar assessment is not to be confused with the ten-dollar assessment voted by the 1943 House of Delegates for special educational activity; no part of this ten-dollar assessment has been used for the ordinary expenses of the Michigan State Medical Society).

4. That the individual members of the House of Delegates become "Ambassadors" of our Postgraduate Foundation and encourage other Doctors of Medicine, as well as laymen interested in sound medical service and education, to contribute during life and in their wills to the MSMS Foundation for Postgraduate Medical Education.

Respectfully submitted,

V. M. Moore, M.D., *Chairman*
O. O. Beck, M.D., *Vice Chairman*
R. S. Morrish, M.D., *Chairman, Publication Committee*
E. F. Sladek, M.D., *Chairman, County Societies Committee*
C. E. Umphrey, M.D., *Chairman, Finance Committee*

Philip A. Riley, M.D.
Wilfrid Haughey, M.D.
R. J. Hubbell, M.D.
T. E. DeGurse, M.D.
W. E. Barstow, M.D.
Roy C. Perkins, M.D.
O. D. Stryker, M.D.
A. H. Miller, M.D.
W. H. Huron, M.D.
Dean W. Myers, M.D.
E. R. Witwer, M.D.
P. L. Ledwidge, M.D., *Speaker*
C. R. Keyport, M.D., *President*
A. S. Brunk, M.D., *President-Elect*
L. Fernald Foster, M.D., *Secretary*
Wm. A. Hyland, M.D., *Treasurer*

ANNUAL REPORT OF DELEGATES TO AMA, 1944

The regular delegates from Michigan were all present and took an active part in the proceedings of the 94th Annual Session of the American Medical Association held in Chicago, June 12 to 16, 1944. There are many delegates from other states who either are in-

different or take little interest in crucial matters affecting the organization. Many are out-and-out specialists and only manifest interest when their "ox is gored." Many have secured economic independence and have little interest in the general subject of economics as it affects the man in the "sticks." Others enjoy a ride on the bandwagon and, like puppets, perform when the "old guard" pulls the string.

Changing events in "world affairs" determine the keynote activities. A few years ago the Michigan delegates were in the "doghouse" because they sponsored pre-payment medical service and pre-payment plans. Ten years ago Michigan delegates were called Bolsheviks because they wanted a central office in Washington and a fieldman who was a public relations diplomat. Today the Council on Medical Service and Public Relations has adopted all these recommendations which first came from Michigan.

The proceedings have been published in an edited and expurgated form in *The Journals of the American Medical Association* on June 24 and July 1, 1944. Michigan delegates presented all the subject matter that had been delegated to them by the State Society or by interested members.

The Resolution to change the structure and enlarge the field of activities of the American Medical Association was introduced by Dr. Gruber and referred to the Reference Committee on Executive Session which reported that "it had given a great deal of consideration to these resolutions. It feels that the resolutions contain valuable suggestions but is not clear as to how these recommendations can be carried out from a practical standpoint. Therefore, it recommends that resolutions be returned to the Michigan State Medical Society for clarification and more specific recommendations."

This Resolution, approved by the 1943 MSMS House of Delegates, read as follows:

WHEREAS, Medical associations and societies in the United States are organized under the provisions of a charter as laid down by the various state laws for organizing such groups, and from a perusal of these charters it appears that under the purposes set forth such organizations are for the sole purpose of carrying on charitable, educational and scientific endeavor, and

WHEREAS, The advice received at present, at least is to the effect that neither the American Medical Association nor any of its component societies (State and County) under present charters have any right whatsoever to engage in economic or political activities but have only the right to engage in such activities as set forth above, and as stated in the provisions of the laws under which these organizations are incorporated, and

WHEREAS, The American Medical Association is at present exhibiting a most decidedly defeatist attitude because of these provisions and is exhibiting this attitude principally expressed as because of fear of taxation, and other fears, and

WHEREAS, The practitioners of medicine who pay dues to these various medical organizations and support them, including the American Medical Association and each of its component societies, desire that these medical organizations in addition to the above set forth objectives, concern themselves with economic and other aspects of medicine as well, and

WHEREAS, It should seem proper to change the complexion of the organizational setup for medical associations and societies so they might be eligible to engage in other than scientific, educational and charitable endeavor and to pay taxes, which might require the raising of dues or whatnot, the above suggested change would attain a free and untrammeled position for them in the political and economic structure of these United States of America so that the medical associations and societies, local, state and national, may assume their place as a force for the benefit of the practitioner as well as the benefit of the patients they serve, realizing that good medicine depends on freedom from fear, at least (which is one of the great freedoms recognized in the Atlantic Charter), this fear being fear of persecution under the existing setup, be it, therefore

RESOLVED, That an appropriate resolution be prepared for presentation to the House of Delegates of the American Medical Association, demanding the organizational setup of organized medicine be so changed and amended as to permit of economic and political activities being carried on by the American Medical Association as well as by its component societies (state and county), and be it further

RESOLVED, That the American Medical Association be instructed to, if necessary, pay taxes whatever may be assessed, and, be it further

RESOLVED, That appropriate steps be taken to provide the necessary fiscal readjustment, and be it further

RESOLVED, That this action be officially presented by the Delegates from the State of Michigan to the House of Delegates of the American Medical Association at its next meeting, and be it further

RESOLVED, That a copy of this action be forwarded to each State Medical Society in the United States with an appropriate letter of transmittal, and be it further

RESOLVED, That a copy of this action be forwarded to each member of the House of Delegates of the American Medical Association, and to each member of the Board of Trustees of the American Medical Association.

Of interest to a large number of practicing physicians was a resolution introduced by a Michigan delegate recommending the creation of a Board of General Practice. This was referred to the Reference Committee on Medical Education which rejected the proposal on the ground of lack of jurisdiction but recommended that the proposal be referred to the Council on Medical Education and Hospitals for transmission to the Advisory Board for Medical Specialties. It is of interest here to note that in the section registration, "The Sessions on General Practice" was fourth—being beaten only by (1) "Practice of Medicine"; (2) "Surgery," and (3) "Obstetrics and Gynecology." Thirteen other sections also ran.

The report on the resolutions recommending the replacement of the present editor of *The Journal of the American Medical Association* will be presented at the Executive Session of the meeting of the House of Delegates of the Michigan State Medical Society.

The resolution opening the gate to membership in the American Medical Association for members of the National Medical Association was sidestepped by saying that it was a local matter for component County Medical Societies and outside the jurisdiction of the American Medical Association.

A resolution lifting the Sex Discrimination from young women desiring to study medicine met the disapproval of the Reference Committee on Medical Education and was quietly interred by referring it to the Council on Medical Education.

A resolution from California requesting the endorsement of the United Public Health League, which is at present maintaining an office in Washington, was disapproved.

The Michigan delegates received a telegram from the Detroit Ophthalmological Society requesting opposition to the request of the Optometric Society for better recognition. The request of the Detroit Ophthalmological Society was complied with and duly executed.

There is no change in the attitude of the profession regarding Maternal and Infant Care for wives and infants of enlisted men, but a resolution to transfer the activities of the U. S. Children's Bureau to the U. S. Public Health Service was approved. On the other hand a resolution to consolidate Federal Health activities in a single Federal Health Department was disapproved with the explanation that monies should be allocated to local and state authorities from the Secretary of Labor for local determination.

The 1945 meeting will be held in New York, and Atlantic City was selected as the place of meeting in 1947. This date marks the 100th Anniversary of the American Medical Association and extensive preparations are already in progress to fittingly celebrate the occasion.

Respectfully submitted,

HENRY A. LUCE, M.D., *Chairman*
T. K. GRUBER, M.D.
C. R. KEYPORT, M.D.
L. G. CHRISTIAN, M.D.
FRANK E. REEDER, M.D.

ANNUAL REPORT OF MENTAL HYGIENE COMMITTEE, 1943-44

During the year, two official meetings were held, as well as several discussion groups of the members of the Committee with other groups for consideration of important psychiatric considerations.

1. Recommendation by the Committee was made to The Council concerning a speaker on Neuropsychiatry at the 1944 Postgraduate Conference on War Medicine. The need of having at least one speaker on this subject appeared obvious by virtue of the significant role which psychiatry is playing in war medicine, with particular reference to Induction Station procedures and casualties in the Armed Forces. The Committee suggested three names, and of these Colonel William C. Menninger was selected. He has agreed to present a discussion at the 1944 Postgraduate War Conference in Grand Rapids.

2. The Committee expressed the need for more complete and better academic training in psychiatry in Medical Schools, particularly in view of the need for psychiatrists at the present time.

3. The problem of premarital instruction was raised and the Committee expressed the opinion that it would be glad to work on the project, providing this met with the approval of The Council of the Michigan State Medical Society.

Following the approval of The Council for the Committee on Mental Hygiene to proceed with the question of premarital instruction, it appeared feasible to approach this problem from the standpoint of two phases: the first phase to be a presentation to the practitioners of medicine of the state, material which would stress the importance of this subject, particularly with the relationship between sexual problems and the development of various disorders; thus, this might consist of articles in The Journal of the State Medical Society and discussion at the postgraduate conferences sponsored by the State Medical Society, the University of Michigan and Wayne University Medical School. The second phase would be the carrying of this material to the public. It seemed inadvisable to do any work on the second phase at the present time.

The above notes represnt the report of the official meetings of the Committee of January 20 and April 27. In addition, members of the Committee met with representatives of the Bar Association and with representatives of the Judicial Council relative to the development of new and more satisfactory procedures for the admission of patients to state hospitals. This work is being sponsored by the Judicial Council of Michigan and a formal report has gone to that body.

Respectfully Submitted,
R. W. Waggoner, M.D., *Chairman*
R. G. Brain, M.D.
Robert Dixon, M.D.
H. A. Luce, M.D.
R. A. Morter, M.D.
H. A. Reye, M.D.
O. E. Yoder, M.D.

ANNUAL REPORT OF MEDICAL-LEGAL COMMITTEE, 1943-44

During the past year there has been no meeting of the Medical-Legal Committee as a whole. Routine correspondence has been carried on through the Executive Secretary of the State Society. During the year some of the cases pending have been dropped, and payment for legal services in connection with investigation and previous litigation in these cases has been approved.

Respectfully submitted,
S. W. Donaldson, M.D., *Chairman*
Ralph Cook, M.D.
Cyrus M. Gardner, M.D.
E. S. Parmenter, M.D.
Wm. J. Stapleton, Jr., M.D.
E. A. Wittwer, M.D.

PROPOSED AMENDMENTS TO CONSTITUTION AND BY-LAWS OF MICHIGAN STATE MEDICAL SOCIETY

The following amendments to the Constitution were presented at the 1943 Annual Session of the House of Delegates, Michigan State Medical Society, and, according to the Constitution, were referred to the 1944 session of the House of Delegates for final consideration:

Constitution

1. Amend Article III, Section 4, by adding a new sub-paragraph to read as follows:

"Physicians, residents of the State of Michigan, for the period of time they are in active Military Service of the United States previous to their engaging in active practice."

COMMENT: This proposed amendment would make it possible for the County and State Societies to offer membership to Doctors of Medicine residing in Michigan who enter into active Military Service of the United States before engaging in private practice (such as interns and residents).

* * *

2. Amend Article III, Section 4, by adding a new sub-paragraph to read as follows:

"Active Members, by transfer, for the period of time they are temporarily out of active practice on account of protracted illness."

COMMENT: This proposed amendment would cover active members who may be unable to practice medicine for extended periods of time on account of protracted illness and who may either be ineligible for transfer to Retired Membership or be unable to pay annual dues.

* * *

3. Amend Article III, Section 4, Item 4, to read as follows:

"Physicians not engaged in any phase of medical practice, including members not in practice due to protracted illness."

COMMENT: This proposed amendment has the purpose as the proposed amendment No. 2.

* * *

4(a). Amend Article III by adding a new Section to be known as Section 8, to read as follows:

"Life Members. A physician who has attained the age of seventy years or more and maintained an active membership in good standing for ten years or more in the State Society may, upon application and recommendation of his County Society, be transferred to the Life Members' Roster by election in the House of Delegates. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing.

"The County Society of such member shall make request for certification, in writing, to the Secretary of the State Society thirty days or more in advance of the Annual Session."

4(b). Amend Article III, Section 1 by adding to the list of memberships the following:

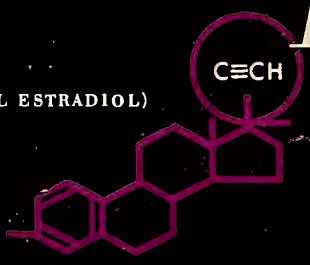
"Life Members."

4(c). "Be it resolved that these amendments shall take effect and be incorporated in the Constitution at the Annual Session following the termination of the present World War."

COMMENT: A resolution was presented in 1942 recommending Emeritus Membership to members at the age of seventy years or more. The Committee on Constitution and By-Laws felt that Life Membership, as proposed above, would represent years of age while Emeritus Membership represents years of service; it also felt that any further reduction of active members paying dues, other than those in Military Service, would seriously reduce the income of the Society and included in its resolution that the above amendment to the Constitution, if approved, shall take effect at the Annual Session following the termination of the present World War.

(Continued on Page 814)

A significant contribution to estrogen therapy



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A tablet preparation designed to meet the demand for an oral estrogen capable of providing all the valued benefits of the true natural hormone at a cost comparable to that of synthetic preparations, and yet, extremely well-tolerated. More potent than any other oral estrogen, ESTINYL alleviates menopausal symptoms readily, and bestows a heightened feeling of general well-being.

Average dose consists of two or three ESTINYL Tablets of 0.05 mg. daily for 1 to 2 weeks, after which one tablet daily or every other day may suffice. If symptoms are easily controlled, one ESTINYL Tablet of 0.02 mg. may be found adequate for maintenance therapy. Available in bottles of 30, 60 and 250 tablets.

Literature on Request

SCHERING CORPORATION SCHERING **BLOOMFIELD · NEW JERSEY**

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(Continued from Page 812)

5. Amend Article VIII, Section 2, to read as follows:

"The House of Delegates at each Annual Session shall elect the President-Elect, the Speaker and Vice Speaker of the House of Delegates, and the Councilors. These officers shall be installed in the general meeting at which the reports of the House of Delegates are received. They shall serve until the corresponding time of the next annual session except that the Councilors shall serve for five annual sessions. The terms of the Councilors shall be arranged so that not more than four terms expire normally at any annual session. All these officers shall serve until their successors are elected and take office.

"At the annual session next following his election the President-Elect shall be installed into and assume the office of Presidency immediately following the annual address by the retiring President and shall serve until the corresponding time of the next annual session. This assumption of office shall occur in the general meeting at which the reports of the House of Delegates are received.

"If no general meetings are held at the annual session, then induction into the office of the incoming president and the newly-elected officers shall be in the last meeting of the annual session of the House of Delegates.

"The Secretary, the Editor of the JOURNAL and the Treasurer shall be elected by the Council in its annual meeting in January of each year. They shall take office immediately and serve for a term of one year or until their successors are elected and take office."

COMMENT: This clarifies the election of the President-Elect who automatically becomes the President when the Presidency becomes vacant.

By-Laws

6. Amend Chapter 6, Section 9 to read as follows:

"The Committee on Ethics shall consist of five members appointed by the President with the approval of the Council to serve for five-year terms, so staggered that one member is selected annually, except that in 1944 one member shall be selected for a five-year term, one for a four-year term, one for a three-year term, one for a two-year term, and one for a one-year term.

"If a member dies, resigns, or is disqualified prior to the expiration of his term, the President may appoint a successor to serve until the next meeting of the Council which, if it approves, may select him to serve the unexpired portion of the term.

"The following rights and duties devolve on the Committee:

"1. To render, on the request of the Council or of a component society, advisory opinions on questions of ethics submitted to it;

"2. To assist county societies in setting up schemes of integration between such county society committees as have duties and functions similar to the duties and functions of this committee and the Medico-Legal Committee of this Society;

"3. To integrate, so far as possible, its activities with the activities of the Medico-Legal Committee of this Society;

"4. On the request of a component society or of any member of this Society, to conduct such investigation or hearing, or both, as it deems appropriate, concerning the professional conduct of any member of this Society and to report to the component society to which the physician under inquiry belongs, its findings and conclusions as to the ethical propriety of the conduct in question for such further action as the component society may deem proper, provided however, that in the event of a finding adverse to the physician under inquiry if the physician agrees to amend his conduct to conform with the conclusions of ethical propriety made by the Committee, the Committee may in its discretion dispose of the matter and report its action to the appropriate component society;

"5. If a component society fails to institute disciplinary proceedings against a member with respect to whom the Committee has filed an adverse report, in its discretion to prefer written charges in the form and manner specified by the component society's organic laws with the secretary of the component society involved and, through a member or members of the Committee, to perform all acts that are reasonably necessary and proper in the prosecution of such charges; and

"6. To make annual reports to the State Secretary.

"A member who is guilty of any of the following acts shall be subject, in the discretion of the county society, to expulsion, suspension, or admonition:

"1. A criminal offense involving moral turpitude;

2. Gross misconduct as a physician or citizen;

3. Violation of the Principles of Medical Ethics;

4. The willful commission of any act tending to defeat the aims, purposes, or objects of this Society or to bring the Society into disrepute;

5. The willful refusal to adhere to the Constitution and By-Laws of the Society; or

6. The giving of any testimony in any court of law or administrative proceeding which in the opinion of the Council of the Society is reckless, willfully false or fraudulent, or is not in keeping with the dignity or scientific standards of the profession."

COMMENT: This proposed amendment, to clarify the duties of the MSMS Committee on Ethics, was considered briefly by the 1943 House of Delegates which referred it back to the Committee on Constitution and By-Laws for study.

A RAY OF UNDERSTANDING

(Continued from Page 785)

the medical examiners of the Army and Navy—then in the first full flush of the new vogue of intelligence tests—that the people of the United States were 14 years old in the head. Books were written in vast numbers to prove that we were a nation of morons. Since then these statistics have been discarded.

What we would like to read is comparative statistics. How does the manhood of America rank today with the physical findings revealed in the last war which made possible a general national health tabulation? Have we deteriorated or improved in the past 25 years? What is the state of our national health as compared with that of other nations?

Some of the experts blame our present civilization and mode of life on the conditions they find today. How do they know? At no other time in history have such statistics been available. In no other war—except the last one—was any such system of physical and mental examination attempted. Up until World War I there was no compulsory universal military service. So, such contentions on the present health of the Nation are not scientifically sound.

* * *

All we do know is that insurance statistics show that in the past half century the span of American life has been extended 10 years, which would indicate a steadily growing improvement in our national health. In the days of Shakespeare a man was considered old and finished if he arrived at the age of 50. Today a man of 50 considers himself in his prime and is more worried about his golf score than he is about his arteries.

Military examiners are of necessity perfectionists. Millions of men too frail for the rigors of battle can live to healthy old age, long past the span of life of their more athletic fellow mortals.

Nevertheless, the challenge has been made. It is agreed, whether our health has improved in recent generations or not, that the physical state of our people is not good. There is room for vast improvement.

As group medicine develops, along with the furtherance of the science of public health, there will be established—voluntarily—annual medical inspections. From such sources we may gather sound statistics on which to base our judgments.

In all this progressive effort the medical associations should take the lead. If they do not accept their social responsibilities, the people will eventually insist that the Government move in.

Basis for many uses

The pharmacologic actions of Luminal have been applied with great advantage in the clinical management of a variety of conditions and disorders . . . This well established drug exerts a sedative, hypnotic, antispasmodic and anticonvulsant effect . . . The desired result is often only a matter of dosage . . . Continued freedom from symptoms, as in epilepsy, may be obtained by the determination of the suitable maintenance dose in individual cases.

Write for informative booklet containing detailed clinical information and helpful dosage table.



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MICHIGAN'S DEPARTMENT OF HEALTH

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

MICHIGAN BLOOD PLASMA PROGRAM

September 27 marks the first anniversary of the Michigan's Civilian plasma program. As the year ends free blood plasma is available for all practicing physicians in forty-seven counties where blood donor clinics have been held or where they are definitely scheduled for this summer. Most of the larger cities have been skipped in the beginning of this program because through hospitals plasma is available in these areas. Eventually every county in the state will be covered. At the beginning of the program the state health department agreed not to schedule its bleeding unit within 40 miles of Detroit until after the war, since this is the area in which the Red Cross recruits blood donors for the armed services.

Physicians' reports on the use of plasma show that 50 per cent of the patients were suffering from shock, either postoperative or traumatic. Thirteen per cent of the cases were victims of burns and 12 per cent had some complications associated with pregnancy.

Reports this summer show an increased use of plasma for infants with diarrhea and for premature infants.

As the first state to attempt such a comprehensive project, Michigan now has a plasma program that is a working model for the nation. Its success is due to a four-way coöperation between local chapters of the American Red Cross which enlist donors and organize the bleeding clinics, the general public which donates blood, the Michigan Department of Health laboratories which hold the clinics and prepare the plasma, and the physicians who administer plasma to their patients.

At present the doctor and six nurses of the plasma field unit are booked almost a year in advance and many requests for clinics are having to be held until other mobile units are available. Another bottleneck of the program has been that the laboratory can handle only a fraction of the blood that people want to give.

To expand the laboratory facilities, Governor Kelly appealed to the special session of the State Legislature in January, 1944. The result was that $250,000 was set aside for development of the plasma program. At present the contract has been let for the "plasma building" which will actually be a second story on one of the existing buildings of the laboratories.

In each clinic Dr. A. B. Mitchell, Medical Director of the State Plasma program, and the six nurses, bleed four to six persons simultaneously. At the end of each day, the blood is rushed to the laboratories at Lansing.

Here each sample of blood is tested for syphilis . . . the red cells are removed and the plasma is filtered. It is tested for sterility and for safety, put into half-pint bottles and labeled for distribution. For each county that has given blood, a blood bank is established, with a credit based upon the amount of blood donated. Ten per cent of their credit is withheld for emergency use in case of disaster.

DOCTOR ALVAREZ IN NAVY

Dr. Russell de Alvarez, field consultant in obstetrics in the Bureau of Maternal and Child Health for the past five years, is now a Lieutenant (sg) in the U. S. Navy, stationed at San Diego.

100 PER CENT CLUB FOR 1944—MSMS

Allegan—J. E. Mahan, Secretary
Alpena-Alcona-Presque Isle—E. S. Parmenter, Secretary
Barry—H. S. Wedel, Secretary
Bay-Arenac-Gladwin-Iosco—L. F. Foster, Secy.
Branch—James Bailey, Secretary
Clinton—T. Y. Ho, Secretary
Dickinson-Iron—E. B. Andersen, Secretary
Eaton—L. G. Sevener, Secretary
Grand Traverse-Leelanau-Benzie—Robert T. Lossman, Secretary
Hillsdale—John A. MacNeal, Secretary
Houghton-Baraga-Keweenaw—R. J. McClure, Secy.
Huron—J. Bates Henderson, Secretary
Jackson—H. W. Porter, Secretary
Lapeer—H. M. Best, Secretary
Livingston—Ray M. Duffy, Secretary
Luce—Sidney Franklin, Secretary
Manistee—C. L. Grant, Secretary
Mecosta-Osceola-Lake—John A. White, Secretary
Medical Society of North Central Counties—Stanley A. Stealy, Secretary
Menominee—Wm. S. Jones, Secretary
Midland—Ralph R. Sachs, Secretary
Muskegon—Helen S. Barnard, Secretary
Newaygo—H. R. Moore, Secretary
Oceana—W. Heard, Secretary
Ontonagon—W. F. Strong, Secretary
Sanilac—E. W. Blanchard, Secretary
St. Clair—A. L. Callery, Secretary
Tuscola—John C. Shoemaker, Secretary
Van Buren—R. W. Spalding, Secretary

As of August 10, the above county medical societies have certified 1944 dues for every member of their respective societies, to be the first 100 per cent paid-up counties for this year. A number of other societies have certified all but one or two of their 1944 members. As soon as these have paid their 1944 dues the list of 100 per cent county societies will be much larger.

Prescribe a balanced food . . .



Lederle CEREVIM*

A VITAMIN FORTIFIED, PRE-COOKED CEREAL

CEREVIM HAS BEEN FORMULATED by authorities on nutrition as a very important article of the diet for an important member of the household, the baby. In deciding its content many questions arose—

Should it contain cereal grains? Whole wheat meal, oat meal, wheat germ, yellow corn meal and barley were added.

Should it include protein of high biological value? Dried skimmed milk, one of the best sources of such protein, was added.

Should it include natural vitamin B complex? Dried brewers' yeast was added.

Should it contain additional vitamins to make sure of ample supply? Thiamine hydrochloride (B_1), riboflavin (B_2) and niacin (anti-pellagra factor) were added.

Should it contain added iron and calcium? Both were introduced into the formula.

Was this an ideal balance of nutrient vitamins and minerals? It was put to the test of microbiological assays, chemical analysis, animal feeding experiments, and then compared carefully with the daily vitamin allowances recommended by the Food and Nutrition Board of the National Research Council. It met these tests easily.

CEREVIM has been found highly satisfactory in

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✶ COUNTY AND PERSONAL ACTIVITIES ✶

M. K. Newman, M.D., of Detroit, appeared on the program of the American Medical Association Scientific Assembly, held in Chicago the week of June 12.

* * *

Paul D. Bagwell, Head of the Speech Department, Michigan State College, addressed the Battle Creek Lions Club on July 25. His subject was "The Spread of Federal Bureaucracy."

* * *

Wm. J. Burns, Executive Secretary of the Michigan State Medical Society, addressed the Beta Chapter of Nu Sigma Nu at its post-initiation banquet, University Club, Detroit, on August 9. His subject was "Has Medicine Been a Failure?"

* * *

The Woman's Auxiliary to the Wayne County Medical Society recently purchased and presented to the Red Cross Blood Bank a station wagon, to be used by the Motor Corps in transporting blood donors to and from the Blood Bank.

Congratulations, Doctors' Wives!

The Annual James D. Bruce Testimonial Lecture will be presented the first day at all Postgraduate centers, this autumn. The Hirshfeld Lecture on "Penicillin" has been designated as the 1944 Bruce Testimonial Lecture.

James D. Bruce, M.D., is the present and longtime Chairman of the outstanding MSMS Committee on Postgraduate Medical Education.

University of Illinois College of Medicine announces its Fall Didactic and Clinical Refresher Course for specialists in Otolaryngology, September 25-30. For information, write Department of Otolaryngology, 1853 W. Polk Street, Chicago 12, Illinois.

* * *

Harvard Medical School, with the coöperation of Boston U. Medical School and Tufts College Medical School, offers a seminar in Legal Medicine, the week

(Continued on Page 820)

AN ADDED Service to the Medical Profession

Urine Analysis
Blood Chemistry
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Special Tests
Basal Metabolism
Serology
Parasitology
Mycology
Phenol Coefficients
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THE SAME dependable service you have always found at Central Laboratories is now available on a *six hour pregnancy test*—the GONESTRONE Test.

The latest and most reliable of the tests for determining pregnancy, the GONESTRONE is a modification of the Aschheim-Zondek and Friedman Tests, and was originated by Drs. Salmon, Geist, Frank and Salmon. In approximately 1,000 comparative tests made during the past year in our research department, we have found the GONESTRONE to be almost 100 per cent accurate.

In this, as in other clinical tests and chemical analyses made in our laboratories, your work will be handled with thoroughness and exactitude. . . . Your patients will find pleasant, well-equipped examining rooms. . . . You will approve our fees.

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- **Ammoniated Mercury Ointment 5%**
- **Greaseless Calamine Ointment Compound**
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- **20 c.c. Estrogenic Hormones in Corn Oil**
  (2,000 International Units per c.c.)
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  Solution of Mixed Natural Estrogens Derived from Equine Urine
- **Solution of Thiamine Hydrochloride**

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THE effectiveness of Mercurochrome has been demonstrated by more than twenty years of extensive clinical use. For professional convenience Mercurochrome is supplied in four forms—Aqueous Solution in Applicator Bottles for the treatment of minor wounds, Surgical Solution for preoperative skin disinfection, Tablets and Powder from which solutions of any desired concentration may readily be prepared.

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is economical because stock solutions may be dispensed quickly and at low cost. Stock solutions keep indefinitely.

Mercurochrome is antiseptic and relatively non-irritating and non-toxic in wounds.

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* * *

Nathan Frenn, M.D., of Bark River and E. S. Sawbridge, M.D., of Stephenson, were elected President and President-Elect, respectively, of the Upper Peninsula Medical Society at its meeting of July 28 in Houghton.

Escanaba was selected for the 1945 meeting of the Society.

* * *

Let Your Newspaper Editor Know. Inform the editor of your newspaper that you will be in Grand Rapids for the 1944 Postgraduate Conference on War Medicine—the 79th Annual Session of the Michigan State Medical Society, September 27-28-29.

Please bring your Michigan State Medical Society or your American Medical Association membership card, to facilitate registration and to save your time.

* * *

Golfers' Attention.—No formal MSMS Golf Tournament has been arranged in 1944 due to the war. However, a number of medical golfers throughout the state desire to play a game or two during the MSMS Annual Session in Grand Rapids. Those interested will be aided in the arrangement of matches if they will write the Golfers' Committee, c/o Pantlind Hotel, Grand Rapids.

* * *

A. S. Brunk, M.D., Detroit, President-Elect of the Michigan State Medical Society, has been appointed as the MSMS representative to a Special Advisory Committee on Minimum Standards for Governmental Agency Programs. This Committee is headed by L. S. Woodworth, M.D., of Detroit, and was appointed at the request of and advisory to Wm. DeKleine, M.D., State Commissioner of Health.

* * *

Overheard during the Mackinac Island Races, July, 1944.—Young matron, visibly irritated at the prolonged absence of her young husband, busily dancing at the Grand Hotel with a beautiful young blonde, remarks to her female companion: "To think that I spent $13.90 out of a birthday check from my father for vitamins for that bird—and look at him now. See what *my* vitamins are doing for *him!*"

* * *

Public Addresses.—J. S. DeTar, M.D., of Milan, a member of the MSMS Public Relations Committee, presented six addresses recently on "Federal Bureaucracy." He addressed the Washtenaw County Medical Society, the Rotary Clubs of Milan and Saline, the Rotary-Lions Clubs of Mt. Clemens, the Monroe Exchange Club, and a joint meeting of Monroe physicians, attorneys and pharmacists.

Otto K. Engelke, M.D., of Ann Arbor, addressed the Ann Arbor Public Forum on "Regimentation."

Howard H. Cummings, M.D., Ann Arbor, spoke to the Woman's Auxiliary to the Washtenaw County Med-

(Continued on Page 822)

Say you saw it in the Journal of the Michigan State Medical Society



IF A PATIENT
WANTS INFORMATION
REGARDING THE

ADVANTAGES

of internal menstrual protection

Primarily, the unique functional design of the Tampax vaginal tampon accounts for its numerous advantages—anatomic, physiologic and psychologic.

As one gynecologist[1] stated, at the conclusion of a study involving more than 2,300 cases of all types (many of whom employed Tampax over extended periods): "The patient does not even know that a tampon is present in the vagina if it is inserted sufficiently deep." He continued, "Many say they can forget that they are menstruating and so are without the disturbing annoyance they had every time they menstruated."

A general practitioner[2], after studying 21 patients, remarked: "All patients were favorably impressed after using the tampons. Some said that they eliminated the chafing and itching caused by the usual external pads. Some said that they eliminated a 'wet feeling' or 'unpleasant odor'. Others preferred them because they could indulge in sports with greater freedom."

And another specialist[3], after observing 110 women (both single and married) who employed vaginal tampons throughout each period for from 1 to 2 years, reported that "because of the greater comfort experienced, 103 subjects preferred to continue to use the tampons through part or all of the menstrual period rather than to return to the use of the perineal pad alone."

Such opinions reflect the reactions of thousands of women in all walks of life who have experienced the advantages inherent in the Tampax method of menstrual hygiene.

(1) West. J. Surg., Obst. & Gyn., 51:150, 1943.
(2) Clin. Med. & Surg., 46:327, 1939.
(3) Am. J. Obst. & Gyn., 46:259, 1943.

TAMPAX

ACCEPTED FOR ADVERTISING BY THE JOURNAL
OF THE AMERICAN MEDICAL ASSOCIATION

TAMPAX INCORPORATED
PALMER, MASSACHUSETTS

Please send me a professional supply of the three absorbencies of Tampax.

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Name_____

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"EUREKA! I THINK THIS IS IT!"

SAID A DOCTOR WHEN SHOWN THE SPENCER BREAST SUPPORT



SPENCER BREAST SUPPORTS

Hold Heaviest Ptosed Breasts in Healthful Position

Improve circulation and tone, rendering breasts less likely to inflammation or disease. Encourage squared shoulders, aiding breathing. Release strain on muscles and ligaments of chest, neck, shoulders and back.

Aid Prenatal, Postpartum patients by protecting inner tissues, helping prevent outer skin from breaking; guard against caking and abscessing during postpartum.

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Please send me booklet, "How Spencer Supports Aid the Doctor's Treatment."

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POSTGRADUATE MEDICAL CONFERENCE
Rackham Building, Ann Arbor, Michigan
October 13, 1944
9:30 A.M-4:30 P.M.

Subjects

The Management of Benign and Malignant Inter-thoracic Neoplasms. JOHN ALEXANDER, M.D.
Circulatory Actions of the Veratrum Alkaloids .....GORDON K. MOE, M.D.
Psychiatric Aspects of Chest Pain ....RAYMOND W. WAGGONER, M.D.
Medical Treatment of Diseases of the Thyroid Gland .....CYRUS C. STURGIS, M.D.
Surgical Treatment of Diseases of the Thyroid Gland .....FREDERICK A. COLLER, M.D.
Postural Tension as a Cause of Pain..... .....CARL D. CAMP, M.D.
Naevi of the Skin; Diagnosis and Treatment .....STURE JOHNSON, M.D.
Diseases of the Salivary Glands..... .....A. C. FURSTENBERG, M.D.
Toxemias of Late Pregnancy..... .....NORMAN F. MILLER, M.D.

A cordial invitation is extended to all physicians to attend this program.

Department of Postgraduate Medicine
University Hospital
Ann Arbor, Michigan

ical Society, as well as to the Nurses' Association of Ann Arbor on "What Price Security?"

* * *

Frank L. S. Reynolds, M.D., long-time Secretary of the Gogebic County Medical Society, has left Ironwood and the superintendency of Grand View Hospital. His new work brings him to Oneida, N. Y., where he can be reached at 472 Main Street.

Dr. Reynolds was always tremendously interested in the work of organized medicine and as Secretary of his county medical society, performed a creditable job for his community and for the State Medical Society.

* * *

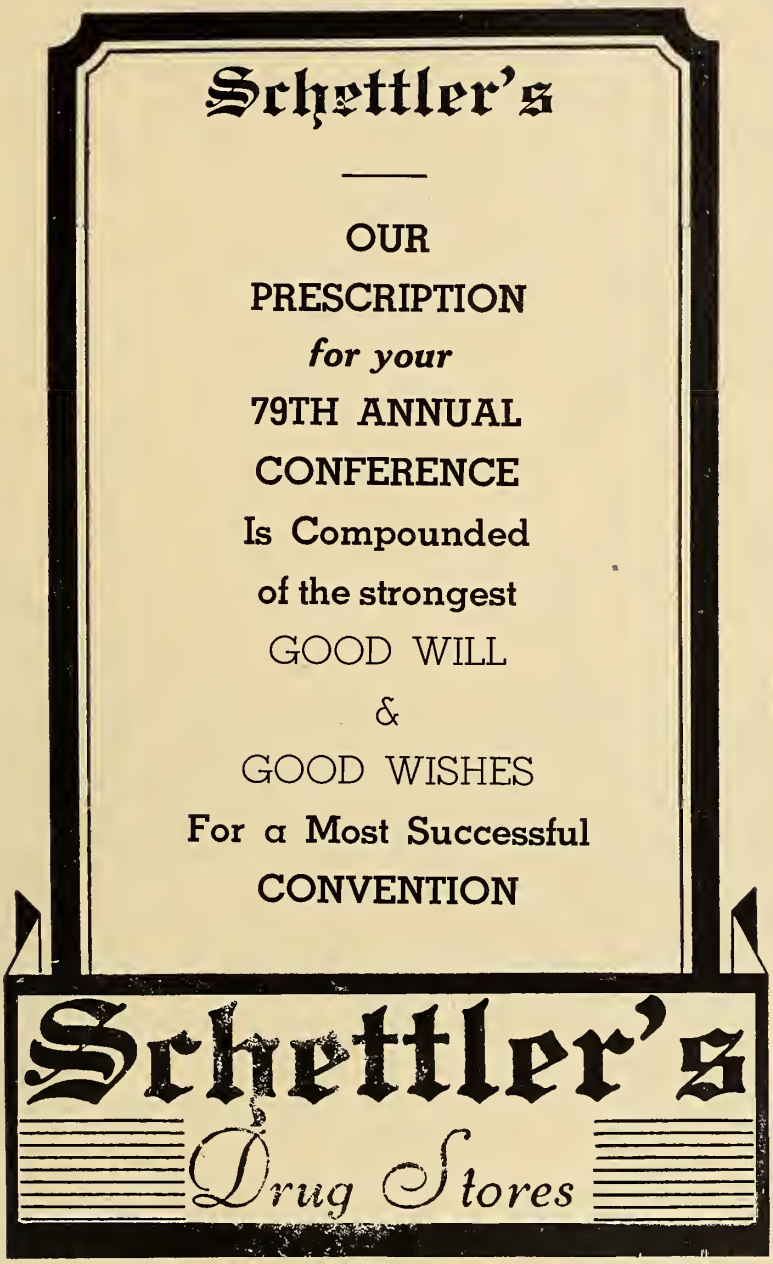
The Editor of the Detroit Medical News, W. B. Harm, M.D., received signal recognition by having his editorial "An Open Letter" which appeared in the August 7, DMN, reprinted in full in Malcolm W. Bingay's famous column "Good Morning," in the *Detroit Free Press.*

The theme of Dr. Harm's letter, addressed to Lt. Marshall Dann of the U. S. Navy, Somewhere in the Pacific, was graphically expressed by Mr. Bingay in his column of July 15.

* * *

The Wayne County Medical Society recently sent out a questionnaire to its doctors to ascertain membership interest in the WCMS Health Program for Industry.

(Continued on Page 824)



DETROIT and GROSSE POINTE

A BORN LEADER—
THAT'S
JOHNNIE WALKER



BORN 1820
Still going strong

Its unrivaled smoothness and distinctive flavour makes Johnnie Walker a leader among scotches.

Popular Johnnie Walker can't be everywhere all the time these days. If occasionally he is "out" when you call... call again.

JOHNNIE WALKER



BLENDED
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RED LABEL
BLACK LABEL

Both 86.8 Proof

Canada Dry Ginger Ale, Inc.
New York, N. Y.
Sole Importer

BUY UNITED STATES WAR BONDS AND STAMPS

The postal card questionnaire stated: "Industry looks to the doctors to improve industrial health conditions, accentuated now by war production and shortage of medical personnel. The Society has accepted the responsibility of undertaking a program . . . your program."

Details may be obtained by writing the Committee on Industrial Health of the Wayne County Medical Society, 4421 Woodward at Canfield, Detroit 1, Michigan.

* * *

COUNCIL AND COMMITTEE MEETINGS

Postgraduate Extension Committee, Ann Arbor—June 30

Maternal Health Committee, Statler Hotel, Detroit—July 6

Ethics Committee, Olds Hotel, Lansing—July 9

The Council, Mackinac Island—July 21-22

Michigan Medical Service, Board of Directors—July 23

Michigan Health Council—July 23

Maternal Health Committee, Statler Hotel, Detroit—Aug. 10

Executive Committee of The Council, Detroit—Aug. 24

The Council, Pantlind Hotel, Grand Rapids—September 25 and 28.

* * *

The Alpena physicians were hosts to the Officers and the Councilors of the Michigan State Medical Society on Thursday, July 20. A scheduled golf game was changed to an afternoon of indoor entertainment, due to rain; an excellent dinner, prepared by the Woman's Auxiliary, was served.

E. S. Parmenter, M.D., Secretary of the Society, was Chairman of Arrangements for a very pleasant day. Representing the State Society were President-Elect A. S. Brunk, M.D., Detroit, Councilor C. E. Umphrey, M.D., Detroit, Secretary L. Fernald Foster, M.D., Bay City and Executive Secretary Wm. J. Burns.

* * *

The Liquor Control Commission, on September 10, 1943, ruled on the following arrangement: "For certain patients whose conditions require the consumption of amounts of liquor per day which is more than the amount permitted by the ration rules, the Doctor of Medicine may write a prescription certifying that the patient (mentioning his or her name) is to have X amount of liquor without regard to previous purchases made by the patient on his or her ration card. The prescription is to be signed by the physician.

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* * *

Captain Carl W. Hammer, M.C., was awarded the Silver Star by the War Department for exposing himself to heavy enemy fire in order to treat the seriously wounded and to direct their evacuation from the Normandy beachhead. According to the War Department citation, Dr. Hammer saved numerous lives by his bravery.

Dr. Hammer received degrees from the University of Michigan and Wayne University College of Med-

(Continued on Page 826)

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icine, and interned at Grace Hospital, Detroit. He practiced in Oxford, Michigan, prior to entering Military Service. He is a member of the Michigan State Medical Society.

* * *

MEETING OF MICHIGAN MEDICAL SERVICE MEMBERSHIP

The fifth annual meeting of the membership of Michigan Medical Service will be held in the Ballroom of the Pantlind Hotel, Grand Rapids on Tuesday, September 26, 2:00 p.m. The membership is composed of all duly accredited members of the MSMS House of Delegates plus the members of the Board of Directors of Michigan Medical Service.

MICHIGAN MEDICAL SERVICE

Nominations are in order for Directors to succeed the following, whose terms expire September 26, 1944: Wm. J. Burns; Burton R. Corbus, M.D.; Wm. A. Hyland, M.D.; Vernor Moore, M.D.; John Reid; Philip Riley, M.D.; and P. L. Ledwidge, M.D.

Under the By-Laws, nominations are made by a Nominating Committee or may be made by any ten Members of the Corporation at the Annual Meeting.

To assist the Nominating Committee, suggestions are requested from the Members of the Michigan State Medical Society. Please send suggested names to the Nominating Committee, Michigan Medical Service, 1300 Washington Boulevard Building, Detroit 26, Michigan.

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(Continued on Page 828)

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The possibilities of the new program are without limit.—*Detroit Free Press* of July 27, 1944.

* * *

Discussing various types of payroll deductions, the *Buffalo* (New York) *News* points out, in a long, analytic article, that many workers say jokingly they would rather receive the deductions than what is left. Pay envelopes "are due for another slice if the Wagner-Murray-Dingell Bill becomes law." The following interesting table is included in the article.

When the new simplified income tax is effective, the voluntary and compulsory deductions of a single person earning $50 a week will, in an average case, add up as follows:

Withholding tax	$8.20
Social Security	.50
War Bonds (10%)	5.00
Insurance	.15
Savings deduction	5.00
Charity	.50
Hospitalization	.25
Total deductions	$19.60
Balance	30.40

If the Wagner-Murray-Dingell Bill is enacted, the Social Security "take" from this taxpayer would be raised to $3.00 weekly, making the total deductions $22.10 and leaving $27.90 in cash from the $50 pay.

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In Memoriam

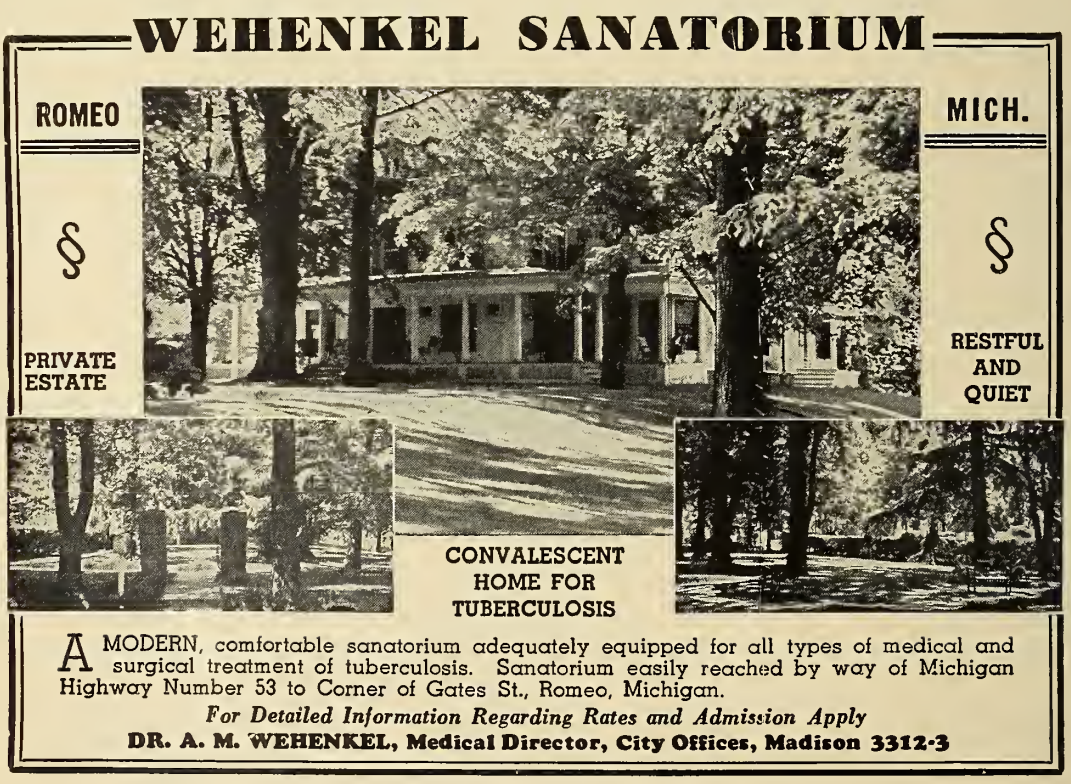
Andrew P. Biddle of Detroit was born February 25, 1862, in Detroit and was graduated from the Detroit College of Medicine in 1886. He was a member of the staffs of St. Mary's Hospital, the Woman's Hospital and the Florence Crittendon Home. Doctor Biddle served for many years in the medical department of the Michigan National Guard and was a major and surgeon with the 31st Michigan Volunteer Infantry during the Spanish-American War. He was president of the Michigan State Medical Society in 1916 and elected to Emeritus Membership in 1933. Doctor Biddle was a Fellow and past-president of the Detroit Academy of Medicine; president of the Board of Education from 1918 to 1919 and a member of the board until 1925, when he was appointed to the Detroit Library Commission. In 1929 Wayne University conferred upon him the honorary degree of Doctor of Science. Detroit's leading medical men gathered in 1936 to honor Doctor Biddle on his completion of fifty years of medical practice. He died August 2, 1944.

C. J. Geenen of Grand Rapids was born in Iowa in 1896 and was graduated from the University of Iowa Medical School in 1926. After serving his internship at Butterworth Hospital in Grand Rapids, he entered general practice in that city, later specializing in surgery. He was senior attending surgeon at Butterworth Hospital, where he died June 7, 1944, from dyscrasia, resulting from an injury received three months ago.

Orla H. Gillett of Grand Rapids was born September 23, 1892, in Holt and was graduated from the University of Michigan Medical School in 1923. He served his internship and was resident physician at St. Mary's Hospital from 1923 to 1926 before opening his office in Grand Rapids. Doctor Gillett was chief of surgery and chief of the staff of St. Mary's Hospital and was chairman of the intern committee. He was on the consulting surgical staff of Butterworth and Blodgett Memorial hospitals and special consultant at the Mt. Pleasant hospital. Doctor Gillett died August 2, 1944.

U. G. Spohn of Fairgrove was born in Pinnebog, November 10, 1870, and was graduated from the Detroit College of Medicine in 1906. He began his practice of medicine in Fairgrove where he remained thirty-seven years. He died July 22, 1944.

J. T. Warford of Lansing was born March 11, 1869, in Fulton County, Kentucky, and was graduated from Tulane University of Louisiana Medical School in 1891. He built a private hospital of forty rooms at Jackson, Tennessee, which he operated for a number of years. He later traveled extensively, finally opening a practice in Denver, Colorado. He located in Lansing in 1917, where he practiced until the time of his death on July 30, 1944.



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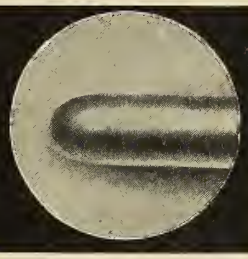
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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient..

THE TREATMENT OF PEPTIC ULCER, BASED UPON TEN YEARS' EXPERIENCE AT THE NEW YORK HOSPITAL. By George J. Heuer, M.D., Professor of Surgery of Cornell University Medical College and Surgeon-in-Chief of the New York Hospital. Assisted by Cranston Holman, M.D., Assistant Professor of Clinical Surgery, Cornell University Medical College, and William A. Cooper, M.D., Assistant Professor of Clinical Surgery, Cornell University Medical College. Philadelphia, London, and Montreal: J. B. Lippincott Company. Price $3.00.

Ten years' experience in the treatment of peptic ulcer in the Surgical Department of the New York Hospital, and the Cornell University Medical College have been collected and studied in an effort to evaluate the best methods and procedures to attain the highest percentage results in the treatment of this admittedly troublesome disease. A chapter is devoted to the medical treatment, its results, and a description of what was done for the patients. There is a chapter on the surgical treatment with studies of results here also of a long series of cases. The aftereffects of surgical treatment are described. Malignancy is considered as a complication, or reason for radical treatment. There is a study of the literature, and a summary. The book is largely statistical, but gives the author's ideas of the very best methods, and when to use them.

THE INTERNATIONAL BULLETIN—POLIOMYELITIS: (Rosenow). Volume 44. From the Mayo Foundation for Medical Education and Research, University of Minnesota, Rochester, New York: The International Bulletin, 319 West 103rd Street, 1944.

Dr. Rosenow's research on infantile paralysis has been recognized in this Bulletin, the whole volume being devoted to him and his work. The study of pleomorphic diplococci and streptococci, and their relation to virus is outlined, and efforts to find and success in finding a method of prevention of this disease is given in detail. The work is extremely technical, but lucidly explained. There are graphs, pictures, tables and references. It is an outstanding addition to our sum total of knowledge of poliomyelitis, and will unquestionably have its part in leading us to success in treatment.

PRINCIPLES AND PRACTICES OF INHALATIONAL THERAPY. By Alvan L. Barach, M.D., Associate Professor of Clinical Medicine, Columbia College of Physicians and Surgeons; Assistant Attending Physician, Presbyterian Hospital. 59 Illustrations. Philadelphia, London, and Montreal: J. B. Lippincott Company, 1944. Price $4.00.

The author gives a historical sketch of the development of inhalation therapy, a study of the air gasses, and the gradual realization that some inert gases can be substituted for others, and that oxygen can be given in various concentration. Inhalation therapy includes the decompression for bends, administration of oxygen for asphyxia, and later treatment for intractible asthma, pneumonia, edema of the lungs, congestive heart failure, anoxia, migraine, postoperative atelectasis, et cetera. The definition of each condition studied, the pathologic physiology, and the inhalation therapy are carefully and

(Continued on Page 834)

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completely given. This book is a revelation of new methods, and very practical as well. We have enjoyed reading it, have learned much, and found it one of those books you stay with far into the night.

FUNDAMENTALS OF PSYCHIATRY. By Edward A. Strecker, M.D., Sc.D., F.A.C.P, Profesor of Psychiatry and Chairman of the Department, Undergraduate School of Medicine, University of Pennsylvania; Psychiartist to the Pennsylvania Hospital; Attending Psychiatrist, Psychopathic Division, Philadelphia General Hospital, Consultant to the Bureau of Medicina and Surgery, United States Navy; Consultant to the Secretary of War, A.A.F. Second Edition. 15 Illustrations. Philadelphia: J. B. Lippincott Company. 1944. Price $3.00.

Psychosomatic medicine dates from Socrates in the fifth century, B. C., but its lessons are ever with us. During the present war we have rejected probably more selectees for some form of psychiatric condition than for any other reason. Every physician must deal with psychoses. This is not just another book on the subject. It is a well-prepared text dealing rather fully, but not verbosely with the subject, and is based upon the author's teaching experiences.

THE ANALYSIS AND INTERPRETATION OF SYMPTOMS. By Cyril M. MacBryde, M.D., Paul B. Beeson, M.D., Richard H. Freyberg, M.D., Edwin F. Gildea, M.D., Sara M. Jordan, M.D., Sidney A. Portis, M.D., Leon Schiff, Ph.D., M.D., David M. Skilling, M.D., John R. Smith, M.D., and Harold G. Wolfe, M.D. Philadelphia, London anl Montreal: J. B. Lippincott Company. 1944.

This is a reprint from *Clinics,* starting with page 1343 to 1644. It is a compilation of treatises on some of the commonest symptoms which bring the patient to the doctor. Emphasis is placed on analysis and interpretation, with special stress placed upon pathologic physiology. Analytical thinking is stimulated, and a more true diagnosis is sure to follow. A few of the symptoms studied are nervousness and fatigue, fever, headache, thoracipain, cough and its differential diagnosis, abdominal, pain, hematemesis, jaundice, joint pain. It is a very helpful book.

TECHNIQUE IN TRAUMA. PLANNED TIMING IN THE TREATMENT OF WOUNDS, INCLUDING BURNS. By Fraser B. Gurd, M.D., C.M., and F. Douglas Ackman, M.D., C.M., in Collaboration with John W. Gerrie, M.D., C.M., Edward S. Mills, M.D., C.M., and Frederick Smith, M.D. Preface by John S. Lockwood, M.D., University of Pennsylvania, with Commentary by Ralph R. Fitzgerald, M.D., C.M., McGill University. From The Montreal General Hospital and McGill University. Philadelphia, London, and Montreal: J. B. Lippincott Company, 1944. Price $2.00.

The increasing importance of burns in both military and civilian life is the excuse for this small volume. It gives day-by-day outlines of treatment of burns and other trauma, with pictures, charts, and several valuable colored charts. The major burns are placed in a burn tent with temperature raised to 80 degrees. Shock is immediately counteracted, and plasma immediately given by continuous drip preferably. Each step in treatment is given in one, two, three order up to nine. For the industrial surgeon and the military surgeon this is a valuable guide.

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Vol. 43 OCTOBER, 1944 No. 10

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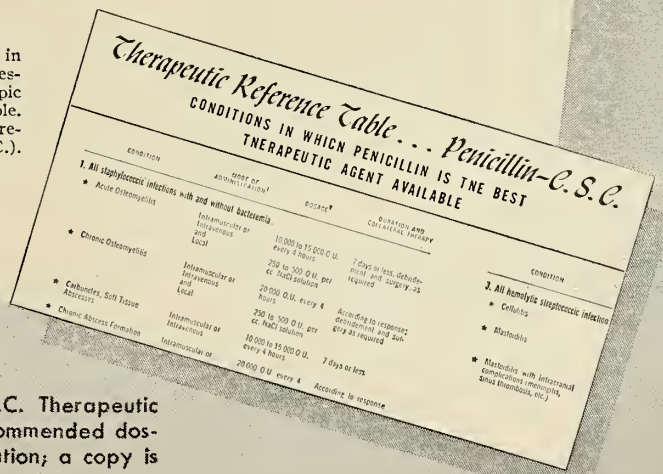
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Reprint available on cigarette research —Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

Detroit Is Host to Association of American Medical Colleges

All Michigan doctors and their families and friends are invited to hear Charles F. Kettering, famous General Motors vice president, research genius, and thought-provoking speaker, at the Hotel Statler in Detroit at 7 p. m. Monday evening, October 23.

The occasion is the annual dinner of the Association of American Medical Colleges. Dr. Edgar H. Norris, dean of the Wayne University College of Medicine which is host to the Association, promises the dinner will be an epochal affair. More than a thousand guests are expected, and connecting ballrooms, especially decorated, will be thrown open to receive them. There'll be a topnotch band. More than 200 Wayne medical students, in uniform will be seated at special tables. The speaking program will be compressed to the single highlight—Mr. Kettering's address.



You'll meet these men at the annual dinner of the Association of American Colleges of Medicine on Monday, October 23. In the center is Dr. Edgar H. Norris, dean of Wayne University's College of Medicine and over-all co-chairman of the convention. At the right is Dr. Burt R. Shurly, immediate past president of Detroit's Board of Education which operates Wayne University, and veteran member of the Wayne Medical faculty. At the left is Judge Edward P. LaJoie, chairman of the Buildings and Grounds Committee of the Medical Science Center of Wayne University. The three are studying a model of the projected $50,000,000 Medical Science Center.

Wives and friends are welcome at the dinner. It being wartime, dress will be informal. Tickets are $3.50, and may be reserved right up to the banquet time by writing or telephoning the Wayne University College of Medicine, 1512 St. Antoine, Detroit 26, Michigan. The College of Medicine has reserved plenty of rooms at the Statler, in case guests should wish to make the dinner the climax of a Detroit week end.

Dr. Norris urges that doctors stay for the entire three-day session. The program of the 55th annual meeting of the Association follows:

Monday, October 23

Postwar Medical Education—George S. Eadie, and W. C. Davison, Duke University School of Medicine.

Graduate Medical Education in the Postwar Period.—C. Sidney Burwell, Harvard Medical School.

Discussion opened by Harold S. Diehl, University of Minnesota Medical School.

Declaration of the Teaching Program—Donald B. Tressider, Stanford University; C. C. Carpenter, Bowman Gray School of Medicine; J. Roscoe Miller and George H. Gardner, Northwestern University Medical School.

Discussion opened by Francis Scott Smyth, University of California Medical School.

Address of President—E. M. MacEwen, State University of Iowa College of Medicine.

Tuesday, October 24

The Teaching of Physical Diagnosis—Gordon B. Myers, Wayne University College of Medicine.

Requirement of Internship for Graduation—L. R. Chandler, Stanford University School of Medicine; William Pepper, University of Pennsylvania School of Medicine; C. D. Creevy, University of Minnesota Medical School.

Discussion opened by Stanley Dorst, University of Cincinnati College of Medicine.

The Internship: When to Contact Students, Time of Appointment—Joseph Turner, Director Mount Sinai Hospital, New York; L. S. Woodworth, Associate Director Harper Hospital, Detroit and President Michigan Hospital Association.

Discussion opened by R. C. Buerki, University of Pennsylvania Graduate School of Medicine; Jean A. Curran, Long Island College of Medicine.

(Continued on Page 852)

CAMP ANATOMICAL SUPPORTS for NEPHROPTOSIS



TOGETHER with treatment for any existing infection of the urinary tract, Camp Supports have proven valuable adjuncts in the relief of symptoms in many cases.

Camp-trained fitters have been instructed to consult the physician as to the position required for the fitting, if reclining or partial Trendelenburg. In the event that the physician desires the use of a pad, the fitter has been instructed to obtain information as to the type of pad to be used and to ask the doctor to mark on the garment or blue pencil upon the patient the exact location of the pad.

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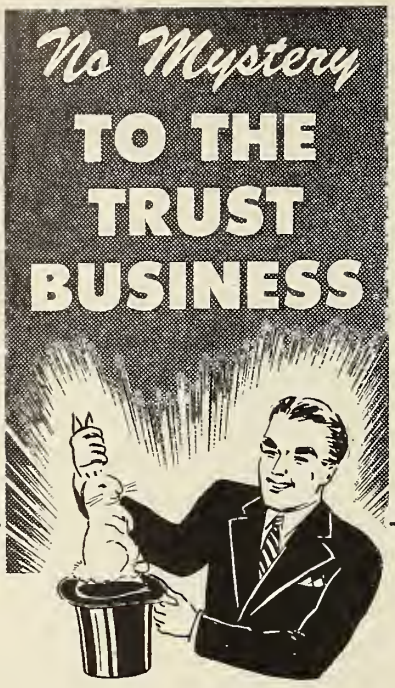
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If our ads have a slang-y tone, that's the way we want them to sound . . . because we're plain-folks, the same as you. And, in spite of our backlog of safe-and-sound resources we haven't a closed door to anyone.

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600 GRISWOLD ST.
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DETROIT IS HOST TO AMERICAN MEDICAL COLLEGES

(Continued from Page 850)

Wednesday, October 25

The Teaching of Parasitology and Tropical Medicine —DANIEL E. HALSEY, Wayne University College of Medicine.

Mixed Task Forces in Medical Education—WILLIAM DOCK, Long Island College of Medicine.

Integration of the Curriculum: Ovredepartmentalization—JAMES A. GREENE, Baylor University College of Medicine; GEORGE T. HARRELL, JR., and HERBERT M. VANN, Bowman Gray School of Medicine.

Discussion opened by E. STANLEY RYERSON, University of Toronto Faculty of Medicine.

A Study made by the Illinois Academy of Science on Premedical Education—C. I. REED, University of Illinois College of Medicine.

Discussion opened by GEORGE H. GARDNER, Northwestern University Medical School.

MSMS RADIO PROGRAM

Departing from traditional standards, "that the general public may have a more intimate knowledge of the great contributions and tireless efforts of the doctors who serve them," the Michigan State Medical Society has entered the field of advertising via radio.

Stressing the importance of maintaining the private practice of medicine and of increasing the use of prepayment medical and hospital plans, the Society is sponsoring a series of five-minute transcribed dramas on twelve Michigan stations.

The thirteen-week series, which began July 31, is being heard twice weekly on the following stations:

WXYZ—Detroit	WDMJ—Marquette
WDBC—Escanaba	WSOO—Sault Ste. Marie
WKBZ—Muskegon	WELL—Battle Creek
WBCM—Bay City	WFDF—Flint
WJIM—Lansing	WIBM—Jackson
WOOD—Grand Rapids	WHDF—Calumet

Titled "American Medicine," the sketches are dramatized by professional actors and portray historic episodes in medicine. Closing commercials of each include the lines:

"Led by Michigan, thirty-seven states now have voluntary prepayment medical or hospital plans developed by the medical profession and the hospitals.

"No theoretical plan, sponsored and controlled by federal bureaucrats and paid for by you, should replace the tried and proven system of private practice now in use."—*Advertising Age,* Aug. 6, 1944.



Constipation probably is encountered more frequently than any other condition the physician is called upon to treat.

A new method of treatment is "Smoothage" as provided by Metamucil. With "Smoothage" the need for harsh cathartics or intestinal irritants is obviated.

METAMUCIL is a highly purified, non-irritating extract of a seed of the psyllium group, Plantago ovata (50%), combined with dextrose (50%). It provides gentle physiologic impulses which activate peristalsis.

INDICATIONS: Chronic Constipation • Hemorrhoids • Colitis • Special Diets • Constipation of Pregnancy, Convalescence, Senility.

• Metamucil is supplied in 1-lb., 8-oz. and 4-oz. containers.

G·D·SEARLE & CO.
ETHICAL PHARMACEUTICALS SINCE 1888
CHICAGO
New York Kansas City San Francisco

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

Metamucil is the registered trademark of G. D. Searle & Co.

SEARLE
RESEARCH IN THE SERVICE OF MEDICINE

WAR BULLETINS

36TH GENERAL HOSPITAL

Michigan's own 36th General Hospital unit, organized under auspices of the Wayne University College of Medicine and staffed by Detroit and Michigan men and women, has won highest commendation from the commanding officer of Headquarters Peninsular Base Section in Italy.

The 36th was stationed at Naples during the early months of the Italian campaign. The quarters it occupied have lately been returned to Italian civilians, and the 36th, recently detached from the Peninsular Base Section, expects immediate assignment to another war area. The commendation reads:

"Upon the separation of your organization from the Peninsular Base Section I wish to express to you, your officers, nurses and enlisted personnel my sincere appreciation of the excellent performance of your various duties while assigned to this Base.

"It has indeed been a pleasure to have your organization with this command and I regret your separation from the Peninsular Base Section. The professional ability and untiring devotion to duty of the members of your organization have done much to add to the comfort and well-being of casualties admitted to your hospital. You should each be justly proud of a task well done."

The 36th General Hospital unit has been overseas for twenty months. It was organized under Wayne University College of Medicine auspices, by authority of the Secretary of War, and its roster includes fifty-two physicians, 105 nurses and about 500 enlisted personnel. Virtually all of these are from Detroit and Michigan. The 36th followed the invading Americans from Africa to Italy, and was the first general hospital to start professional activities on the continent. This is the same hospital that served in France in the other war under Col. B. R. Shurly.

SURGICAL OPERATING TRUCKS TAKE HOSPITAL TO WOUNDED SOLDIER

The Army Medical Department has established Mobile Surgical groups, which provide hospital facilities for wounded soldiers near the front lines. The tent is carried on a two-wheel trailer along with an electrical generating unit; the hospital vehicle can be made ready for full operation within thirty minutes. Sufficient room is provided for operating teams composed of surgeons, nurses and technicians, making it possible for two men to be operated upon simultaneously. The unit is capable of caring for from eighty to 100 men a day. The truck is equipped with a variety of special instruments for orthopedic, nerve, chest, maxillofacial and brain surgery; operating tables, steam and dry sterilizers, lighting equipment, medicines, blood plasma, bandages and dressings, record files, auxiliary power unit, surgical linens and operating gowns.



MICHIGAN FLIGHT SURGEON RECEIVES MEDAL

An Eighth Air Force Bomber Station, England—Captain Harold A. Timreck, thirty-one, of Tawas City, Michigan (left) is pictured receiving congratulations from his base commander, Lieutenant Colonel Glendon P. Overing of Orange, Massachusetts, upon receiving the Soldier's Medal for his heroic action in helping save the lives of airmen trapped in a flaming plane. Captain Timreck, a flight surgeon at this Eighth Air Force heavy bombardment base, practiced medicine in Gladwin County, Michigan, before entering the AAF in May, 1941. He received his wings November 5, 1942. The son of Charles Timreck, Jr., of Tawas City, he is married to Mrs. Myrna Lou Timreck of the same place.

THE REORGANIZATION OF THE OFFICE OF THE SURGEON GENERAL

The post of Assistant Surgeon General, to be filled by Brigadier General Raymond W. Bliss, was created in a partial reorganization of the Suregon General's Office it was announced on August 25. General Bliss will hold the new post in addition to his duties as Chief, Operations Service.

The Assistant Surgeon General will act for the Surgeon General in co-ordinating the work of the Operations Service, the various professional divisions, the

(Continued on Page 856)



Benzedrine Inhaler in the ARMED FORCES



Benzedrine Inhaler has for some time been available to Flight Surgeons for distribution to high altitude flying personnel of the Army Air Forces for the relief of nasal congestion.

It has now been made a standard item for issue to all Army personnel on presentation by physicians.

Smith, Kline & French Laboratories, Philadelphia

Benzedrine Inhaler



Rapid, Complete and Prolonged Shrinkage

Each tube is packed with racemic amphetamine, S.K.F., 200 mg.; oil of lavender, 60 mg.; menthol, 10 mg.

War Medicine

(Continued from Page 854)

Military Personnel Division and the activities of other divisions and services that affect operations.

Other organizational changes include dissolving of the Administrative Service, the Fiscal, Legal and Office Service Divisions of that service will report directly to the Executive Officer as previously; the Professional Service is dissolved and four Professional Consultant Divisions are created as follows: Medical, Surgical, Neuropsychiatric and Reconditioning; the Nursing Division is dissolved and all personnel and related aspects of the Army Nurse Corps will be the responsibility of the Army Nurse Branch of the Military Personnel Divisions, Personnel Service with over-all policy aspects of the Army Nurse Corps the responsibility of the newly-constituted Nursing Division of the Professional Administrative Service.

A new Professional Administrative Service is created, with Colonel Arden Freer as Chief and Colonel Esmund R. Long, Deputy Chief. It will include the following: Physical Standards Division, Nursing Division, Medical Statistics Division, Professional Inquiries Unit, Women's Health and Welfare Unit.

THE WHOLE BLOOD PROGRAM OF THE SURGEON GENERAL

The first shipment of whole blood from the United States to soldiers wounded in France was made by the U. S. Army Medical Department by Army plane on August 21. Daily shipments have been made since; 250 pints a day the first week, 500 pints a day the second week and 750 pints a day will be shipped soon.

Type "O" blood is being collected by the Red Cross for the shipments in response to appeals from Major General Norman T. Kirk, Surgeon General of the Army and Rear Admiral Ross T. McIntyre, Surgeon General of the Navy.

The whole blood is prepared for shipment on the day it is drawn, and 21 hours after it leaves the United States, is available for transfusion in France.

Brig. General F. F. Rankin and Colonel B. N. Carter, of the Surgical Consultant Division with Lieut. Colonel Douglas B. Kendrick, consultant to The Surgeon General on Transfusions and Plasma, developed the program for the Army Medical Department. New developments in the preservation and refrigeration of whole blood were worked out to make the plan effective.

REQUIREMENTS LISTED FOR SANITARY CORPS OFFICERS

Sanitary Corps officers have been placed in a scarce category. The Preventive Medicine service, The Surgeon General's Office, is seeking qualified men to become commissioned officers, and has announced the minimum requirements of enlisted personnel for appointment as second lieutenants. Applicants must have a bachelor's degree with an appropriate science major, and a minimum of two years' experience in the particular field in which the applicant is qualified. In exceptional instances (upon the specific recommendation of their commanding officers) bacteriologists, biochemists, serologists, and parasitologists may be considered for a commission upon the completion of one year of Army laboratory experience.

FOUR THOUSAND ARMY NURSES NEEDED IMMEDIATELY

The Army Nurse Corps, in conjunction with the Office of War Information, the Red Cross, the National Nursing Council for War Service, the War Manpower Commission, and the Recruiting Publicity Bureau of the Army, is making a concentrated effort to obtain 4,000 nurses before October 1, 1944. The need is urgent because of the increasing number of casualties.

REPAIRING SPECTACLES AT THE FRONT

Optical Repair Unit trucks have been devised by the Medical Department to provide repair and replacement facilities for spectacles in overseas theaters. Special bodies have been built which contain complete optical repair shops. These optical repair units are mounted on two and a half ton trucks; their mobility enabling them to keep up with advance forces making it possible to issue and repair spectacles for troops. The truck is equipped with heat and electricty and is so devised that the staff of seven can work at one time. Each unit is staffed by one officer and six enlisted men who are opticians skilled in the maintenance of spectacles; it is capable of turning out between eighty and 100 complete spectacles a day.

HOSPITALS STAFFED BY GERMAN DOCTORS OPENED IN OKLAHOMA

The Army Medical Department has established a separate prisoner-of-war hospital staffed with doctors and medical corps men of the prisoner's nationality. The first hospital, Glennan General Hospital, having a bed capacity of 1,700, has been established at Okmulgee, Oklahoma, for German war prisoners. American Army doctors are the chiefs of the medical services. Eight German physicians have been assigned to medical work. It is anticipated the number will be increased to thirty or forty.

The Medical Department's new policy is in accord with the Geneva Convention Treaty which stipulated that "It shall be lawful for belligerents reciprocally to authorize, by means of private arrangements, the retention in camps of physicians and attendants to care for prisoners of their own country."

Six to one is now the average ratio of federal to state civilian employes. Approximately three million people or, roughly, five per cent of the working population of the United States now work in the executive branch of the Federal Government.

The striking success of Paredrine-Sulfathiazole Suspension in nasal and sinus infections is largely due to its prolonged bacteriostatic action. When the Suspension is administered on retiring, for example, sulfathiazole can often be observed on infected mucosa the next morning—conclusive evidence that bacteriostasis has persisted all night long.

The fundamental reason for this prolonged bacteriostatic action is the fact that Paredrine-Sulfathiazole Suspension—not a solution, but *a suspension* of free sulfathiazole—covers the nasal mucosa with a fine, even frosting of sulfathiazole, which does not quickly wash away. Yet the Suspension does not cake or clump, and does not interfere with normal ciliary action.

Other outstanding advantages:

1. The Suspension does not irritate or sting, because its pH is slightly acid, and identical with that of normal nasal secretions.

2. The Suspension does not produce such central nervous side effects as insomnia, restlessness and nervousness.

Smith, Kline & French Laboratories, Philadelphia, Pa.

PAREDRINE-SULFATHIAZOLE SUSPENSION

1 *Prolonged* bacteriostasis

2 *Non-stimulating* vasoconstriction

3 *Therapeutic* pH—5.5 to 6.5

YOU AND YOUR BUSINESS

PORTABLE UNITS FOR TUBERCULOSIS SURVEYS

■ Many of our members have questioned the present status of the tuberculosis surveys as they are being carried on in the State of Michigan by the Department of Public Health, and others. There has been criticism of the methods and programs. Numerous Roentgenologists have protested that their field of private practice has been invaded. Others have stated that in the interest of finding all possible cases of tuberculosis, and placing them in line for isolation and curative measures they would co-operate in any methods that promised even fairly promising results. However, even these men thought that the taking of the 11 by 14-inch plates is after all the private practice of medicine, and should not be indulged in by state bureaus.

This question of portable unit surveying for tuberculosis has come up at the meetings of the Council of the Michigan State Medical Society numerous times. It has also been discussed at various of our County Medical Society meetings. To bring the present status of the problem to the attention of our members more clearly we are herewith presenting some of the late conferences. At the meeting of the Executive Committee of the Council on June 22, 1944, discussion took place and the minutes report as follows:

Portable Tuberculosis Units.—This matter was presented by E. R. Witwer, M.D., President of the Radiological Society of North America. He stated that the objective of the Federal authorities was to have an x-ray of every chest in the United States, and further to establish a school in Bethesda to train Doctors of Medicine in six months to one year to interpret these films and then to assign them to some 1,000 portable units which would cover all parts of the United States. He felt that surveys are here to stay and that the medical profession should try to co-operate insofar as it could; but he objected to the follow-up by these portable units in taking full size x-ray pictures of suspicious cases and interpreting them—at government expense—which presents the practice of medicine by government. He stated that a bill had been or was about to be introduced requesting $150,000,000 to make the above-mentioned survey.

The matter was discussed by Drs. Foster-Haughey-Umphrey-Moore-Keyport and Brunk.

"Dr. Moore felt that he must always oppose the use of the 35 mm. film, as unsatisfactory, and that he must oppose the follow-up by the government in taking the larger film—that this work should be sent to the patient's physician. Dr. Brunk felt that the follow-up constitutes the practice of medicine by the state and federal governments.

"State Health Commissioner Wm. DeKleine, M.D., entered the meeting. Dr. Witwer explained the above matters to him, after which Dr. DeKleine presented a statement on the plans of the Bureau of Tuberculosis, State Department of Health, in connection with the Tuberculosis survey. He stated that the units will go into communities only with the approval of the county medical society; they will not go into Detroit, or into industrial plants equipped to do this screening work. Dr. DeKleine stated that he would be glad to refer patients to their private Roentgenologists to make the larger films, if the State Department has sufficient money to cover the expense. He added, 'I promise that the M.D's. will be contacted.' He also promised that he would discuss this matter with George L. Sherman, M.D., of the Tuberculosis Bureau (now on vacation) to see what arrangements could be made, so that the state would not enter the practice of medicine.

"Dr. DeKleine was thanked for his attendance and discussion at this meeting."

Dr. DeKleine presented the following report from the bureau of tuberculosis of the Department of Health, dated June 22, 1944:

"The present mobile photo x-ray unit has been in operation since the fall of 1940. Since that time 127,704 x-rays have been taken on 4x5-inch films in 50 counties in Michigan. Special emphasis was given early in the program to the tuberculosis problem in the Houghton-Keweenaw area in the Upper Peninsula.

"During the 1943 calendar year, 40,267 x-rays were taken with this unit. Twenty-seven counties in Michigan were visited. Forty-five war industries were surveyed, with a total of 16,796 films taken. This truck-mounted, photoroentgen machine has screened as many as 500 persons in one working day. The number of x-rays taken is dependent upon the supplying of a steady flow of people into the bus, and the number of times the bus changes location. Allowance must be made for travelling time and for hooking up the unit for power connections.

"Requests on file for this service during the year far outnumbered the capacity of one unit. An appeal to the district office of the U. S. Public Health Service brought a federal grant for this expansion of this program. Budget revisions in March and April of this year provided a total of $25,253.00 for the purchase of two new 35 mm. photo-fluorographic units, and for supplies, maintenance and personnel for the operation of the units for the remainder of the fiscal year. Bids were opened for this equipment on May 19 and purchase orders were placed with Westinghouse X-Ray Corporation on May 23 with shipment guaranteed within 120 days. One additional technician has already been hired and is now being trained. The units are of the portable type, and will be transported in three-quarter ton panel trucks, and carried into a building where they will be set up quickly and easily. Both trucks (used) are on order and one is now in the state garage where it is being checked.

The U.S.P.H.S. has promised the loan of one complete 35 mm. unit to be available about the first of July, 1944. We were to be notified definitely at least two weeks in advance but have not had this notification to date. Dr. Sherman plans to use this unit in a survey in Oakland County. The borrowed unit will be used until our own new units arrive.

"Oakland County Survey.—Dr. Sherman, Director of the T. B. Bureau, Miss Nash and Miss Fox, organizers for the Bureau of Maternal and Child Health, attended a committee meeting in Pontiac on June 1, to discuss plans for organization of the survey. A list of members of the committee, headed by John S. Lambie, M.D., President of the Oakland County Tuberculosis Association, and former President of the Oakland County Medical Society, is attached. The folder attached contains

(Continued on Page 862)



Estrogenic Substance in Oil

CHEPLIN'S purified preparation of naturally-occurring estrogenic substance is physiologically standardized, and its potency expressed in terms of international units—assuring definite uniformity of action. **ESTROGENIC SUBSTANCE** is isolated from pregnant mare urine and contains principally estrone and estradiol in sesame oil. Indicated in menopausal symptoms and sequelae as pruritus vulvae, senile vaginitis and kraurosis vulvae—also in gonorrheal vaginitis of children. Literature on request.

ESTROGENIC SUBSTANCE IN OIL
for intramuscular use supplied in:

2000 Int. Units per cc.	**10,000 Int. Units per cc.**
5000 Int. Units per cc.	**20,000 Int. Units per cc.**

Each strength is respectively furnished in:

1 cc. ampules . . 6, 12, 25 and 100 per box.
10 cc. vials . . . . . 1 vial & 3 vials per box.
30 cc. vials . . . . . 1 vial & 12 vials per box.

"ACCEPTED STANDARDS AT AN ACCEPTABLE COST"

CHEPLIN BIOLOGICAL LABORATORIES, INC.

(Unit of Bristol-Myers Company)
Syracuse, New York

Say you saw it in the Journal of the Michigan State Medical Society

You and Your Business

(Continued from Page 860)

correspondence which you may wish to look over. Dr. Sherman was impressed with the spirit of co-operation apparent among all those present at the meeting.

"The plan is that the Michigan Department of Health will supply the equipment, chemicals, etc., as well as the technician, a physician to read the films (either full-time or a local physician on contract) and one person to assist in organizational details. Films will be processed in Oakland County and read there. Dr. Sherman has contacted Dr. Kimball, Medical Superintendent of the Oakland County Sanatorium, for assistance in the interpretation of films. The new units are equipped to do re-examinations, when indicated, on 14x17-inch films. Responsibility for follow-up and provision of sanatorium care when indicated, will of course rest with local physicians and the Pontiac City and Oakland County health departments. This is true of all surveys conducted with our equipment.

"Future Programs.—No definite commitments have been made for the two new units except for the Oakland county program. The 4x5 unit is booked solidly through August, 1945. Requests are on file in the Bureau for programs in several state normal colleges and state institutions, and for several county projects which will include mainly industrial surveys. Dr. Sherman plans to work out these new schedules as soon as the first unit arrives and the survey in Oakland county gets under way. He feels that, after he has had an opportunity to observe the new units in operation, it may seem feasible to substitute the new units for some of the programs already scheduled for the 4x5 unit. The new units are more adaptable to mass surveying of very large groups, and have the added advantage of re-ray facilities on the spot.

"As you know, Dr. Sherman visited the industrial survey program conducted in Cleveland by the U. S. Public Health Service. I am attaching a copy of his report of that visit. A representative of the Statistical Division, U.S.P.H.S. will visit Dr. Sherman on Monday, June 26th, to discuss plans for tabulating the results of these surveys. The International Business Machine people have a service through their Grand Rapids Bureau whereby they will tabulate material on punch cards. Dr. Sherman asked me to investigate this service and I have some figures on the cost, et cetera of this plan."

There was a long discussion on this matter at the meeting of the Council on July 21 and 22, 1944, at the Grand Hotel, Mackinac Island. Many opinions were expressed as to the value of these various surveys. It seems to be the general opinion that the 4x5 inch film was most valuable but that the 35 mm. film can now be obtained and the others cannot. Therefore, to promote tuberculosis surveys these should be used until more suitable films and machines are available.

The following extract of the minutes of the Council meeting of July 21 and 22 is presented:

"Portable X-ray Units.—The minutes of the June 22 meeting of the Executive Committee of the Council, on this subject, were read. Dr. Vaughan spoke for himself based on experience in Detroit and gave his experience and background in that city concerning portable x-ray units. The matter was thoroughly discussed by Drs. Hubbell-Riley-Moore-Ledwidge—all of whom felt that the 4x5 film was to be preferred to the miniature or 35 mm. film and further that nothing will supplant the 14x17 stereos for final determination of cases. Dr. DeKleine stated that USPHS has recommended the use of the 35 mm. film and further that it cannot obtain the x-ray machines which can use the 4x5 films due to lack of priority. In discussion, Dr. DeKleine stated "We are in the business of finding tuberculosis—we are not in the treatment business. We will not quarrel with the Roentgenologists, we will not interfere with the private practice of medicine; whenever it interferes with the private practice of medicine, I will call off the program."

This material is presented to give our membership an accurate idea of what is being done on the matter of tuberculosis surveys, and the value of these surveys. Quite generally the roentgenologists have criticized, most of them believing that the 35 mm. film is poor screening, and many of them stating that when it comes to making 14- by 17-inch plates that should be done by x-ray laboratories and not by government bureaus.

LICENSE DENIED

The Supreme Court of New Jersey, on July 18, 1944, decided the case of Jacob L. Newman, an application for mandamus to compel the State Board of Medical Examiners to license him to practice medicine and surgery in New Jersey, by virtue of his license to practice in the State of Massachusetts, or in the alternative to admit him for examination for such license by that Board. He was a graduate of a sub-standard college in Massachusetts, not recognized by the New Jersey Medical Examining Board. In rendering their decision the Judges concluded that the relator had not shown any violation of his rights which entitled him to relief. Therefore, the application was denied.

QUICK FREEZE METHOD USED IN KEEPING DISEASE GERMS

Machinery is releasing a lot of animals for more valuable scientific work as a result of a three-year test just announced by the School of Medicine at the University of Michigan.

The test was to try out quick freeze methods in keeping disease germs. The old system was to inject the germs into laboratory mice or rats or guinea pigs. Then in a few days or weeks, the serum had to be drawn off and a new crop of the animals treated. It was a case of keeping the bugs alive in a living host.

Three years ago Dr. Malcolm H. Soule, bacteriology professor and chairman of the Hygienic Laboratory, read a magazine article on quick freeze for keeping foods. He talked with a refrigeration expert and ordered two special units. The tests just announced were made in these.

Germs which produce four diseases were used. These were equine brain fever, chronic cold sores, meningitis and relapsing fever. The first three were tested for 968 days; the last for twenty-seven months. At the end, the germs were just as potent as at the start.

Sizable savings to laboratories all over the country can result, said Dr. Soule. He pointed out that thousands of laboratory animals plus hundreds of hours of skilled technicians' time, not to mention the dollar cost, can be saved or devoted to other work.

(Continued on Page 864)

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100% NATURAL VITAMINS A AND D

The natural vitamin A and vitamin D of time-proved cod liver oil itself—in the proportions typical of U. S. P. cod liver oil—are provided today, as for many years, in the three convenient dosage forms of

White's
COD LIVER OIL CONCENTRATE
LIQUID • TABLETS • CAPSULES

For infants, antirachitic prophylactic dosage of White's Cod Liver Oil Concentrate *still* costs less than a penny a day. Council accepted, time-tested, widely prescribed—and promoted, without deviation of any kind, to the Medical Profession alone.

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Council on Pharmacy and Chemistry

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NEWARK 7, NEW JERSEY

You and Your Business

(Continued from Page 862)

MEASURES FOR CONTROL OF POLIOMYELITIS

1. During epidemics of this disease children should be kept away from other children and away from homes where there is illness.
2. All individuals should avoid strenuous exercise and becoming over-tired.
3. Careful attention should be given to personal cleanliness, particularly thorough handwashing before eating.
4. Children should be kept out of crowds and away from theaters and crowded transportation facilities until the epidemic season is over.
5. When school is in session, most health authorities agree that children are safer when kept in school than when allowed to play about without adequate supervision.
6. Individuals are urged to avoid tonsil and adenoid operations during epidemics inasmuch as it has been shown that such operations done during an epidemic may predispose to a most severe form of poliomyelitis.
7. Swimming in polluted waters should be avoided and sanitation within the home should be maintained at as high a level as possible.
8. Drinking water should be safe and milk should be properly pasteurized.
9. Flies should be kept away from food.
10. When a case of poliomyelitis occurs in a camp, the camp need not be closed, but the individual with poliomyelitis should be removed and isolated in a hospital and immediate contacts, such as tent or cabin mates, must be placed in isolation for a period of fourteen days. It is advised that the camp director curtail the activity of the individuals attending the camp, allowing no strenuous exercises or fatigue.

* * *

FEE SPLITTING

Two statutes materially affecting the relationship between physicians and hospitals in the State of New York became effective recently. They are respectively Chapter 459 and Chapter 466 of the Laws of the State of New York.

The first of these statutes relates to physicians rendering medical care under the Workmen's Compensation Law. The second applies to physicians generally.

Section 13d of the statute relating to Workmen's Compensation cases (Chapter 459), provides for the removal of any physician from the lists of those authorized to render medical care who:

"(g) has directly or indirectly requested, received or participated in the division, transference, assignment, rebating, splitting or refunding of a fee . . . for medical diagnosis, care or treatment under this chapter; except that reasonable payment, not exceeding thirty-three and one-third per centum of any fee received under this chapter for x-ray examination, diagnosis or treatment, may be made by a physician duly authorized as a roentgenologist to any hospital furnishing facilities for such examination, diagnosis or treatment."

It should also be noted that sub-division 2 of Section 13c of the same statute provides:

"2. No claim for services in connection with x-ray examination, diagnosis or treatment of any claimant shall be valid or enforceable except by a physician duly authorized as a roentgenologist by the industrial commissioner for services performed by such physician or under his immediate supervision."

Chapter 466 is even more sweeping in its provisions. It is an amendment to the Education Law and provides that the license or registration of any physician may be revoked, suspended or annulled if it be found.

"(f) That a physician has directly or indirectly requested, received or participated in the division, transference, assignment, rebate, splitting or refunding of a fee . . . for medical diagnosis, care or treatment under this chapter, except payment, not to exceed thirty-three and one-third per centum of any fee received for x-ray examination, diagnosis or treatment, to any hospital furnishing facilities for such examination, diagnosis or treatment."

"Existing arrangements between hospitals and physicians will have to be modified *at once* in order to comply with these new laws," stated a bulletin issued by the Joint Council of Pathologists, Radiologists, Anesthetists and Physical Therapy Physicians.

* * *

NOVEMBER 7, 1944

If there ever was a time when every Doctor of Medicine should cast his vote in a national election, that time surely lies ahead in November.

* * *

SICKNESS INSURANCE FOR RAILROAD WORKERS

If the Wagner-Crosser bill now pending in Congress (S. 1911) becomes a law railroad workers will be paid benefits during sickness as well as during a period of unemployment, female workers will be entitled to 27 weeks maternity benefits, and annuities may be set up for the surviving members of a worker's family or other relatives. It is backed by the powerful railroad unions, by the Railroad Retirement Board, and by various officials in the Government who have long been planning an expansion of the Social Security Act.

The changes would be financed by an increase in the railroad payroll taxes from $250,000,000 to $350,000,000 a year, and by an increase in the tax paid by employes from $130,000,000 to $230,000,000. The Wagner-Crosser bill, according to its sponsors, introduces entirely new "social concepts." It is in fact a preview of the changes which will be asked at the first opportune moment in the existing Social Security law.

* * *

MICHIGAN'S INTANGIBLES TAX

The intangibles tax recommendations of the Tax Study Advisory Committee would provide the following:

Exemptions: Eliminate the "ceiling"; eliminate the exemption of stocks of corporations whose assets are taxable in Michigan; eliminate the credit union exemption; eliminate the $3,000 exemption on bank deposits and building and loan shares; tax bank and trust company shares as other corporate shares are taxed; narrow the business expense deduction; reduce the $10 deduction to $5.

Rates: Fix the rate on income producing intangibles at 5 per cent, instead of 6; fix the rate on bank deposits and building and loan shares at one-tenth of one per cent; fix the rate on other nonincome-producing intangibles at two-tenths of one per cent, except that such intangibles with a market value of less than five per cent of their face value shall revert to the property tax law for assessment and taxation.—Michigan Public Expenditure Survey.

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Formula

Acetylsalicylic Acid 5 grs.
Pentobarbital Acid ¼ gr.

FOR THE RELIEF OF PAIN

ANALGESIC **SEDATIVE**
HYPNOTIC

Pentobarbital is quick acting and of moderate duration. When combined with salicylates it is more analgesic. It has little effect on the respiration.

Dose

For an adult — one tablet.

Prices Available
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PHARMACEUTICAL MANUFACTURERS

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7 FLOORS OF MEDICAL AND SURGICAL SUPPLIES



POLITICAL MEDICINE

A "Flabby, Ailing Nation"

SHOCKING REPORTS ON HEALTH IN U. S. GIVEN TO SENATORS

By Lansing Warren

WASHINGTON—Gravity of the nation's health as disclosed by examinations for Selective Service and the need for national community action to combat this state of things were brought out Monday at the opening session of the hearings before the Senate Sub-committee on Wartime Health and Education.

The evidence revealed that one third of the men examined for service proved mentally or physically defective, and medical experts are agreed there is urgent necessity for concerted effort to use the information and experience of Selective Service to prepare a national program of health.

TRYING TO SCARE US

Well, I see the boys are at it again. American youth is soft and flabby and gone altogether decadent. There is no health in us and we're all headed for the deminition bow wows. Cassandra puts an onion in her handkerchief and her tears make the Mississippi River look like a creek.

* * *

Now it's that great medical authority Paul V. McNutt and Maj. Gen. Hershey, aided and abetted by Dr. Leonard Rowntree, the only one of them who should know anything about the subject. And with all due respect to Dr. Rowntree, he doesn't either. Nobody does. As I am in the same classification, I can speak freely. My answer to their contentions, is simple and scientific; just one word: Nuts.

The American people are the healthiest in all the world; the tallest, strongest, toughest, most durable collection of human beings ever to live on the face of the earth.

Before this war started we were told that American youth was utterly unfit to live. They were mad wastrels, sick in both head and body. There was no future for this country at all.

* * *

That's what the Nazis thought, too. But when Pearl Harbor was hit, what happened? Don't bother answering. We all know what happened. Eleven million of the most virile fighting men the world has ever known snapped into uniform and have been thrilling the whole world ever since with their deeds of valor and their fighting stamina.

But we are still soft and flabby. One third of our people are physically and mentally unfit. All that sounds terrible until you begin to analyze what they are saying.

Let's take a peek at that terribly sick "one third." They are all classed in F-4 as too feeble to fight. Well, we will start out at Briggs' Stadium with one. There's Rudy York, so big and strong that he makes a baseball bat look like a toothpick. With the possible exception of Babe Ruth he can hit a baseball farther than any other man ever in the game.

* * *

But Rudy is rejected for service because he has some kind of a kink in his knee. Take a gander at him and see if you can find anything decadent about him. Then there is Leo Durocher, "Lippy Lou," the toughest, fightingest baseball player in the National League. He was rejected because he could not hear as well in one ear as the other.

Then, also out at Briggs' Stadium, there is the mighty Dick Wakefield, just discharged from the Navy and not wanted by the Army. Probably has corns or is allergic to chocolate sundaes or something. I dunno. He could pose for a statue of Adonis.

* * *

Also, we have in our midst Frankie Sinkwich, All-American football star, rejected by the Marines and the Army because he has FLAT FEET! One of the fastest, toughest backfield players the game has ever seen. If you tell him he's a weakling and a sissy, Doc, you better do it by telephone—long distance at that.

I cite just a few instances to illustrate how much flapdoodle there is to this testimony about our youth being no good. You can multiply these cases by the thousands.

There is the historic case of the Kentucky mountaineer who walked 75 miles in three days to get to a recruiting station and was rejected because he had flat feet and therefore could not stand the strain of marching! So he walked back home—another 75 miles.

The medical standards set by the United States Army were so high that it is amazing they were able to gather in those 11 million. No such standards were ever demanded in any other nation. No such standards were ever set in any other American war.

And that "one-third" also takes in the wretched colored people of the South and the poor whites who for generations have been the victims of hookworm, malnutrition and every other disease that is associated with poverty. Also our own northern slum areas.

And last of all, these selective service "experts" have no standard to go by. Only in the first World War, when a universal draft was first put into effect, was there ever a survey made of American health. In all other wars nobody ever heard of x-rays, blood tests, and allergies. In the Civil and Spanish-American Wars physical examination was the last thing that was thought of. Nobody bothered examining anybody's teeth.

* * *

Dr. Rowntree says hernia, tuberculosis and venereal disease are the three chief causes for rejections. Our grandfathers took hernia as part of middle age. Today it is the simplest of medical operations. Tuberculosis, once the great white plague, is now classified as a controlled disease and is on its way out. As for venereal disease, there never was a war fought in our history with less evidence of it. And the medical profession knows that it can be eliminated within another 10 years.—By Malcolm W. Bingay, *Detroit Free Press*, July 11, 1944.

Table of Contents

What it Means to Be a Doctor.
Claude R. Keyport, M.D. 883

The Significance of a Complete Preventive Medical Program for Children.
C. Anderson Aldrich, M.D. 885

A Survey of 180 Cases of Syphilis in a Suburban and Rural Community, Ingham County, Michigan.
C. D. Barrett, M.D., and *L. E. Kerr, M.D.* 889

Suggested Inquiry Into Possible Relation Between Albuminuria, Essential Hypertension and Nutritional Deficiency.
William DeKleine, M.D. 897

Tubal Pregnancy.
John M. Sisson, M.D. 900

Memorial Page to Dr. Andrew P. Biddle 904

President's Page:
Great Principles Must Be Fought for—to Be Preserved 905

Editorial:
Doctors for the Future 906

Political Medicine 907

We Still Need a Book 907

President, President-Elect, Council, Other Elections 908

Michigan's Department of Health 910

Woman's Auxiliary 912

In Memoriam 916

County and Personal Activities 920

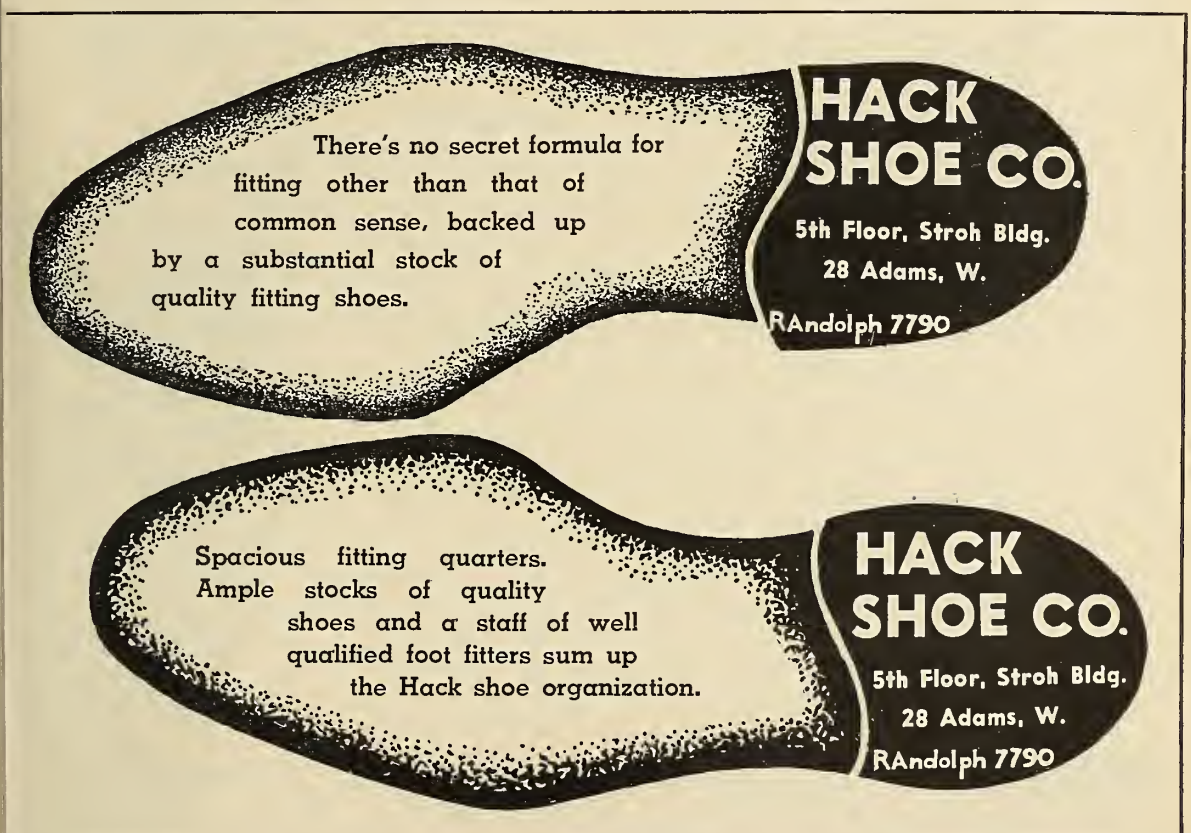
The Doctor's Library 928

Detroit is Host to Association of American Medical Colleges 850

War Bulletins 854

You and Your Business 860

Political Medicine 866





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of the Michigan State Medical Society

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What It Means to Be a Doctor

By Claude R. Keyport, M.D.
Grayling, Michigan



President, Michigan State Medical Society

■ Everywhere men are talking of freedoms—*four* or *more*. Men and women of this organization are wondering today how those in medicine are to realize economic and social freedom, and happiness in work well done. Many doctors are giving hard thought to the significant steps being taken by certain governmental agencies to enslave millions of Americans and make them incapable of freedom.

There is more than a good chance that doctor and patient may emerge from present compulsory plans bereft of any freedoms whatever.

Times press hard; we are confronted with a condition, not a theory. We have examined compulsory systems in use abroad. We are aware of the many mistakes in these systems. We are eager that mistakes made in foreign lands be not duplicated here. By vigilence and care, we can escape history; but if political plans go into operation, history will repeat itself. The public and the profession can suffer through all these mistakes, plus some variegated blunders of strictly American vintage. The only way to escape history is to meet the issue with a better plan. A plan which even the starry-eyed boys must agree will work. If this plan meets the issue squarely and completely, and the public can be fully informed, the people will respond in a manner to match our highest hopes. We have the respect of the public. People are extremely interested, and rightly so, in broader medical service in the post-war period. We can steer ourselves into calm sailing if we not only hold the respect of the public, but, at the same time, increase the popular confidence of the people.

Not only has the machine age altered the gear and pace of our lines, but in the past decade, the world conflict has rendered millions destitute of former patterns of normal living. It is out of this confusion and efforts made to meet its demands that the medical profession is now faced with the possibility of losing the proud gains of public trust.

Most physicians are reluctant to participate in public affairs. They are likewise prone to give little publicity to the rapid changes which attend their training, or make known the struggles they have overcome to achieve the upgrading of their standards. The public, therefore, has no true picture of the doctor today; and only a mild notion of the service he performs. It is not strange, then, to find people clinging to the traditional view of medicine, summed up in the phrase, "Country Doctor." What does it mean to be a doctor? Let us streamline that picture for the average busy citizen. Indeed, let us do better than that, permit us to present the

President's Address at the Fourth Annual Conference on War Medicine, the Seventy-ninth Annual Session of the Michigan State Medical Society, given at the Officers Reception Ceremonies, Wednesday evening, September 27, 1944, Grand Rapids, Michigan.

"Seven Ages of a Physician"

First.—Symbolic of earliest beginnings, the infant, toying with a stethoscope.

Second.—The incident of choice. An accident occurs perhaps. The wish comes to the observing lad to make a body whole again. The wish becomes a resolve and a dedication. (From questionnaires sent to 500 doctors, we find this choice came early in the teens of the candidate for medicine.)

Third.—The medical education. A few decades ago, preparation for the medical profession was a simple and inexpensive matter. Medical colleges accepted students directly from high school. Today, not only a diploma from an accredited high school is necessary; but graduation from the upper third of a class in a four-year college is required by the medical schools throughout this country. Personality, traits of honesty, adaptability, ability to concentrate, friendliness, persuasiveness, are demanded. Only the physically fit are encouraged to continue the gruelling work of four or five more years at a medical school. If the individual has the constitution of an ox, a natural liking for people; if he has optimism and courage and brains, he may graduate and proceed directly to internship of a year or more in a general hospital.

Fourth.—The practicing physician. At this point, the young man is probably twenty-eight years old or more. He is ready to begin his career, arbiter of birth, healer of the sick and maimed, comforter of the aged. He may now marry—or he may wait, realizing the poor financial return from the average practice of medicine. He must, nevertheless, continue to study and practice for the love of the work he has chosen and is pursuing.

Fifth.—The doctor in war—crusader for greater protection of men in service. At the front—thousands of doctors—operating—treating—day and night. Citation after citation has paid tribute to the distinguished service and conspicuous gallantry of these men. All too frequently death on the battlefield ends the career of these young heroes of medicine.

Sixth.—The research hero. In constant search of new serums to prevent or cure disease. Often, unwilling to endanger others, heroic doctors have experimented on themselves. Almost daily reports come of advances made on the frontiers of ignorance and pain.

Seventh.—The doctor's heritage. The gift of experience. Having followed the star of hope, training, serving, striving, the doctor is a master workman. His selflessness—his devotions to truth, have a timeless quality for those who will follow his rugged footsteps.

Can these pictures be brought to the general public? No one has the answer in total; but, certainly, the precise facts of cost, plus years of exacting discipline and changes in the service load of the doctor today represents information, tragically lacking in the *popular conception* of what it means to be a doctor in the swift pace of these stirring times.

We are convinced that a true picture will elevate the individual doctor to sovereign dignity in the mind of the public. It will restore a proper background for the consideration of realities in present problems. Whether or not these techniques will actually be translated into functioning machinery of private medicine, will depend, overwhelmingly, upon whether or not members of our profession have, themselves, a clear understanding of the issues at stake and the resolution to act on that understanding.

We will never prostitute our profession, or the public, with fantastic schemes. We will never weigh unwilling shoulders with greater burdens of fear and costs. We can give leadership instead of simply waiting for things to happen. Indeed, we must lead or be forcibly socialized.

The doctors of Michigan can create plans to meet needs. We can be alert and prepared to make a great many people happier than they ever dreamed they might be. We can have sound voluntary plans to provide medical service, showing our ability to resist the encroachment of government control. We can prove our ability to understand the economic or other side of medicine. We can alter our conception of our profession to include and stress the economic phase of medicine. The medical profession can inject into the American scene a new excitement, a new quality of living. We, too, can go to the people; by fireside, at office desk, or bedside. We, too, can assure the people peace and freedoms.

Doctors, you know the problem. You are cognizant of what must be done. But you must realize that the job must be done by *you*. You must know the facts—the truth—and spread your knowledge. The responsibility is yours, and yours alone. If you will work, you will gain the whole world. If you fail to labor, you will suffer the loss of your heritage, your medical soul.

MSMS

The Significance of a Complete Preventive Medical Program for Children

By C. Anderson Aldrich, M.D.
Rochester, Minnesota



Professor of Pediatrics, Graduate School, University of Minnesota; Director, Preventive Medicine in Pediatrics, Mayo Clinic.

A complete preventive medical program for children must take into account not only the purely physical welfare of youngsters, but also their emotional and mental growth. This is true because it is impossible to separate the two in clinical medicine. How habit formation proceeds in such basic functions as eating, sleeping and eliminating will, of necessity, influence the child's emotional reactions as well as his physical well-being.

If a medical program could be devised which would attain our objectives from a health standpoint and at the same time coöperate with the child's natural developmental plan, we might look forward to a new type of individuality in our children. This is related to the development of a coöperative citizenry which a democracy so evidently needs.

The plan of the Rochester Child Health Project is outlined.

A former public health official from an occupied country in Europe said to me the other day, "We have been educating for this war for forty years! The way we have cared for our babies and young children has encouraged the kind of personality that makes violent conflicts inevitable. Types like Hitler and Mussolini," he went on, "must be expected to develop when we deny to children the secure personal background necessary for normal growth."

This physician was greatly impressed with the possibilities for human development that might be opened up by a community medical program which would take into account, from the first days of a child's life, not only his physical health and welfare but his basic emotional needs as well. This is the kind of program we look forward to in the Rochester Child Health Project.

Development of Pediatric Thought

Before going into the plan, I would like to digress for a few minutes in setting the background of this effort. We pediatricians are responsible for some of the lacks and failures that appear in the field of child care today, as well as for its evident successes. Therefore, it may help you to understand how we came to be interested in this more comprehensive type of program if we review pediatric thought since its beginnings, back about fifty years ago.

This medical specialty started out as a separate division devoted to "diseases of children," and was made necessary by the alarming infant mortality of the late eighteen hundreds. Diphtheria, tuberculosis, intestinal disorders, infectious diseases, the provision of clean milk and water supplies were acute problems which had to be solved, since at that time mortality statistics indicated the death of about one out of every four babies in the first year of life. The effort to improve this situation furnishes one of the bright chapters of medical history, and the scientific management of the children built up for itself a well-deserved prestige.

Now, as time went on this health-bringing program of child care grew to be, in many cases, a meticulous and burdensome regimen. Medical ideas were learned at that time by study in Austria and Germany; and we can see how routines planned with continental efficiency gradually became rigid schedules that had little relation to the reality of a growing child.

Most of us remember the exacting schedules imposed on mothers and children only a few years ago, and the aftermath still persists. Formulas calculated to the ounce were prescribed and mothers were encouraged not to "give in" to their babies, to let them cry it out if the clock had not turned to the proper feeding or bath hour. The behavioristic psychologists made matters worse by their theory that fondling, rock-

Read before the Fourth Annual Postgraduate Conference on War Medicine, Seventy-ninth Annual Session of the Michigan State Medical Society, September 28, 1944, Grand Rapids, Mich.

Published simultaneously in the *American Journal of Diseases of Children*.

ing or singing to a child spoiled him—that the mother who devoted herself to such softening measures would make her son a mamma's boy and a sissy. All the natural motherly emotions were tabooed along with grandmother's rocking chair. In the name of science we took a long step against nature's laws.

But science is really an attempt to interpret nature. When the spirit became lost in the letter of the law, science became unscientific and the children suffered; not in the old way, but in a new way—through behavior disturbances and failure to conform to the autocratic daily standards set up for them. Feeding, sleeping and elimination problems multiplied and tantrums flourished, in spite of the best intentions of doctors and parents.

All this would not have happened had we known what we know today about normal growth and development. But unfortunately, scientific research does not all come along at the same time. Doctors always have to act in the light of what they know today, not of what they *will* know tomorrow. We learned about nutrition and calories before we found out about normal growth. This important piece of the picture puzzle was lacking and is only just beginning to be fitted in now.

For science *does* change when confronted with facts—and a great many facts have been coming along during the past twenty years.

As we all know, a great deal of work has been done in the psychologic field to sift out the factors in a child's early environment, to determine which are helpful and which are obstructive or disturbing.

Educators in our schools have also been applying scientific methods to the school curriculum, and are finding that various subjects can be taught more efficiently when the mental development of a child has reached a definitely appropriate stage.

It is now recognized, for instance, that the ability to read is a developmental step, and that before eye and brain are set for this accomplishment in the individual child, he cannot learn to read well. To know more about the stages of mental development is one of the goals of educational research today.

Most significant of all perhaps, the steps of physical growth are being studied intensively and are giving us a new yardstick for the evaluation of child care. Such research, notably in Dr. Gesell's laboratory, has revealed two important facts. First, there is a startling uniformity in the sequence of human development; for instance, practically all babies sit up, crawl, stand and walk in this sequence. Second, each stage of a child's growth can be predicted accurately from month to month.

Based on these facts, we can plot a developmental schedule of growth which is applicable for all, although the individual rate or speed of growth may vary. For instance, we know that an average normal baby will smile at about six weeks, will be able to reach out for objects with both hands at approximately four months, will develop pincer movements of fingers and thumb at nine to eleven months and will be able to attain bladder control in the second year.

The importance of these simple discoveries cannot be overemphasized, because when their implications sank in, we began to realize that early habit training in eating, sleeping and elimination, as well as the acquisition of early motor skills, was more dependent on the maturation of the child than on our attempts to teach him. It then appeared logical to assume that he could be taught each act most easily when the appropriate developmental stage had been reached. The whole scheme of early education became simpler when we applied to each problem a detailed knowledge of normal growth and development.

With this background we have begun to realize that many of the personality problems parents have been up against with children have come about because they have failed to adjust their child care to the newly discovered facts of growth. We have expected young children to behave in ways for which they were not yet ready. Most of us, for instance, have tried to make them eat from a spoon before their tongue and lip muscles have developed properly. We have tried to "train" them against the current of their natural development. This is illustrated repeatedly in premature attempts to train for bowel and bladder control.

As a result, children have become confused, resistant and subject to emotional storms. We call such children "spoiled." They have really been misfitted. It is obviously we who must do some revamping of our methods, so that our child care can be based on the actual needs of growth

rather than on arbitrary standards we have set up.

What are these needs of growth? Well, we don't know them all. We don't know the full secret of how to nurture children any more than we know all of the secrets of farming or of animal husbandry. But those of us who constantly observe children feel that we do know some of them.

We all agree that children need fresh air, sunshine, adequate clothing, food and sleep. These physical needs are conscientiously aimed at and are a common part of every program for nursery care, including ours.

But there are other things which we have come to see as equally important. Modern babies apparently need a closer contact with their mothers during the first few weeks of life than they are usually allowed. They also need a more self-reliant program; to be fed, for instance, by their own feeding schedule (for every baby *has* one, if we will take the trouble to find it). In fact, all the way along, children need to be allowed to "do their stuff," to use each new ability as it appears; to feed themselves, for instance, as soon as they are able to manipulate a spoon; to walk and climb as they begin to get their equilibrium. For it is back here in these simple nursery activities that a child begins to develop the sense of confidence and competency which we all recognize as vital for his later success.

Rochester Child Health Project

So now we come to our plans for the Rochester Child Health Project. We have two main objectives: first, to offer all the children of Rochester health supervision based on the optimal growth needs of the individual child; and, second, to study the growth of these children from conception to maturity by means of continuous observation and records. It will be a valuable piece of research in itself, to see if a community can be interested in such a program.

It should be mentioned in passing that Rochester, Minnesota, a city of about 30,000, provides an unusual opportunity for this sort of program. Practically all of the children born in that city are under uniform medical supervision. Ninety-five per cent of them are born in one hospital, under the care of clinic obstetricians, and are seen in the home and in the neonatal and well baby stations by the pediatricians of the clinic.

We are more than fortunate also in having the full coöperation and support of our city public health officers, of our medical, nursing and social service agencies, and of the executive officers of our schools. The school system and the health department already have a well coördinated health program and are ready to consider the project as one more phase of their work. In this way we have a unique backlog of help and interest from individuals and agencies in the city. We feel that this wholehearted assistance from Rochester citizens will go far toward making our objectives possible.

We intend to begin with the 1944 crop of babies, trying to set the environment favorably as they progress through the years. As we picture it now, there will be five main age groups, each with its own needs.

The Prenatal Clinic.—In this clinic we will be interested not only in the diet and physical hygiene of the mother, but also in her attitude toward the coming baby. She and her husband will be encouraged to learn what a newly born baby is like, what the baby will need from them, something about the importance of breast feeding, and how to prepare their home for the advent of the new member.

At present, we propose to offer this education partly by means of classes and individual talks at prenatal conferences and partly by a series of leaflets to be filed by the mother in a loose-leaf folder. In the early years, this folder will also be used to summarize the measurements of growth, and to give a record of illnesses, immunizations and any other facts of health interest.

Hospital Care.—After the birth of the baby and during the mother's stay in the hospital, every effort will be made to give both baby and mother not only good physical care but a satisfying and comfortable time together, and to institute breast feeding of as high a percentage of babies as possible.

We anticipate that the technique of caring for newly born babies will have to be studied and modified considerably, and to that end we are now making plans. For instance, on dismissal to go home our mothers are instructed not to be afraid to pick up their babies when they cry unduly, and that rocking chairs are back in style. Most of these modern young mothers are sur-

prised and relieved to learn that they can be motherly.

Well Baby Clinics.—Continuing at the well baby clinic, each baby will be seen at least once a month and oftener if necessary, for a feeding checkup, general health supervision and to receive immunization shots against contagious diseases. Mothers and fathers will also be offered a chance to learn more about the social development and habit formation of their babies at these conferences. This teaching will be based on growth and development.

Preschool Clinics.—We anticipate less frequent follow-ups in formal clinics. Probably some of the work will be carried on through the education of small neighborhood groups of mothers and children, supervised by trained nursery school workers. One or two nursery schools will be developed as demonstration centers. During these years we hope to continue our interest in growth and development as they apply to habit formation and the social interests of the children, and to prepare the children for the public schools so that they will retain the natural desire to learn and the sense of adequacy which we hope to encourage during their early years.

School Health Program.—We will try to protect our children from undue incidence of disease by routine examinations and health supervision. We also hope to continue the study of growth and development in coöperation with the teaching program so that we may utilize the utmost abilities of individual students as they grow.

Research

It is natural that out of such a program should come many questions that need to be answered. Research, therefore, will be an inevitable part of our activities.

Already we have become involved in the question of the excessive crying of babies during the early weeks of life, and are devoting considerable time in an attempt to understand why babies cry and how to prevent this both in the hospital period and after they go home.

At present, in spite of all our care, the highest human mortality occurs in the first two weeks of life. We are trying to collect facts which will help us better to meet the physiologic needs of these young individuals in a most important and critical stage of their growth.

Research has also been started to see if we can correlate the muscular tension of newborns with their emotional behavior. We expect to carry these observations on as the children grow up, to establish whether or not dynamic personalities are born that way and can be so diagnosed at birth.

We realize, too, that there will accumulate over the years a running file of histories of many of the children in the community. Summaries of the salient points in these histories are being accumulated on a punch card system of records so that they may be easily collected at any time for study.

It is anticipated that while we will keep some records of measurements of growth, this phase will not be emphasized. Equal attention will be given to the mental and emotional development of the children under our care.

Application

This means that we will be especially interested in the prevention of behavior disturbances and in encouraging each child to develop his own best possibilities.

This method of attacking behavior problems through early prevention rather than by treating them later in child guidance clinics is a fundamental part of our project. The necessary machinery to treat successfully all the unhappy and mishandled children of any community is beyond the possibility of attainment because of their number. We are interested in finding out whether, by mass education as to prevention, we can obtain a better result with less expenditure of time and money. This seems to us a practical objective when we realize that mental disease is one of the major problems of our time.

It is understood that only the broad aspects of mental health can be reached by such a program. Economic factors, hereditary tendencies as well as the complexity and confusion of our present world are bound to create stresses; but it will be interesting to see how many children brought up in a community where parents understand the implications of normal growth, will get the basic confidence needed to meet these strains. We will never know unless we try.

We feel, too, that we should be and we are interested in a still wider aspect of community development. Such an effort must have some relation to democratic citizenship. We live in a

democracy which we are fighting to preserve. The children now growing up will be its leaders of the future. But we cannot expect to have successful leaders in a democracy unless they are emotionally stable enough to stand on their own feet and give and take freely with their fellow men.

This required emotional stability must stem from a basic security and confidence, the kind that grows up from childhood. It does not seem impossible that human nature may have more coöperative aspects than we have hitherto thought possible. We can make a start at finding this out by applying the wholesome principles of growth to infant and child care.

MSMS

A Survey of 180 Cases of Syphilis in a Suburban and Rural Community, Ingham County, Michigan

By
C. D. Barrett, M.D., Lansing, Michigan
and
L. E. Kerr, M.D., Oberlin, Ohio

C. D. Barrett, M.D.

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L. E. Kerr, M.D.

M.D., 1935—University of Michigan; Chief Bureau Medical Relief, Toledo, Ohio, 1937-38; M.S.P.H.; University of Michigan, 1939; Fellow P. H. Admin. W. K. Kellogg Foundation, 1940; Assistant - Director Ingham County Health Dept. 1940; Commissioner Lorain County Health Dept., 1941-44; Fellow American Public Health Association; Surgeon (Resident)—U.S.P.H.S., 1944—.

■ During the summer of 1940, a survey was made of all the patients reported to the Ingham County Health Department from April, 1938, to June 1, 1940, as having a genito-infectious disease. This study was conducted for the purpose of bringing the department records up to date. In addition to the fulfillment of this primary objective there resulted from the study two other accomplishments, viz., the formulation of a satisfactory record form and card index for health departments not having a clinic under their own jurisdiction and the acceptance by the Ingham County Medical Society of a set of rules for the treatment of indigent patients living outside the City of Lansing based on the recommendations of the Coöperative Clinic and the Advisory Committee on Syphilis Control of the Michigan State Medical Society.

At the time of this study the Ingham County Health Department had jurisdiction over a population of 52,000 and included all of Ingham County except the City of Lansing. The population of Lansing was approximately 82,000. This study included only those cases of genito-infectious diseases residing in the county exclusive of Lansing.

The Ingham County Health Department began operations April 1, 1938. During the twenty-six-month interval from that date to June 1, 1940, the private physicians of Ingham County and the Lansing City Health Center reported 249 cases of syphilis (exclusive of those in Lansing) to the Ingham County Health Department. All cases of gonorrhea in the records of the Ingham County Health Department were given consideration in the survey similar to the recorded cases of syphilis. Due to the brief period the usual case of gonorrhea is under treatment, there were too few cases remaining active to be considered as a part of this study.

An individual record was filled out as completely as possible from the material in the genito-infectious case file. The former assistant director had secured some of these data on selected cases but in the majority of instances the only information available was that which appeared on the laboratory report. The patients were then catalogued as to physician, and each week about seven to ten letters were sent to as many doctors stating that the assistant director would be calling at their office in a few days for information relative to genito-infectious disease cases living in the county which they had under treatment. This was followed by a telephone call making a definite appointment. It is interesting to note that of the seventy-one private physicians interviewed, only one was reluctant to give available information.

Similar information was obtained from the clinic treating genito-infectious diseases in Lansing.

Table I shows the status as determined by investigation of all the cases of syphilis in the active file of the Ingham County Health Depart-

TABLE I. STATUS OF PRIVATE AND CLINIC CASES OF SYPHILIS
Ingham County Rural—June 1, 1940

STATUS	Private	Clinic
TOTALS	168	80
Cured	6	1
Dead	4	1
Moved out of department jurisdiction	23	15
False report	3	
Physician objected to investigator contacting patient	1	
Unable to locate	6	9
Under treatment	83	49
On rest	15	6
Not under treatment	27	

TABLE II. DISTRIBUTION OF ACTIVE SYPHILIS CASES BY REPORTED AGE, SEX, AND MARITAL STATUS
Ingham County Rural—June 1, 1940

Age Groups	Male			Female		
	Single	Married	Other	Single	Married	Other
Totals	23	57	10	17	54	19
Under 10	4			4		
10–19	4			7	3	2
20–29	8	10	1	4	18	8
30–39	1	17	1	1	19	2
40–49	2	18			10	3
50–59	4	9	4		4	2
60 and over		3	4			

ment as of June 1, 1940. Reference to this table shows that six of the cases of lues under treatment with the private physicians were cured and one of the clinic cases was similarly catalogued. Those patients who had moved out of Ingham County, i.e., either into the City of Lansing or another county, were classified as having "moved out of department jurisdiction." This was true of thirty-eight cases. In three instances private physicians felt that the lack of related clinical findings and negative serology following a false positive laboratory report warranted classifying the patients as "false reports." One patient was of such a mental make-up that the attending physician did not feel it would be wise to have the assistant director contact her, although she was delinquent (late latent). It is interesting to note that of the 168 cases of syphilis reported by private physicians, only 3.5 per cent could not be located, while 11.1 per cent of the clinic cases were not to be found. However, due consideration must be given to the different type of patient seen in each instance. The remainder of the study is concerned with those cases of syphilis classified as "Under Treatment," "On Rest," "Continuous Treatment" and "Not under treatment." These constitute 125 cases with the private physicians and fifty-five cases with the clinic. Of the latter group the cases were either under treatment (forty-nine), or on rest (six), while with the private physician 21.6 per cent were not under treatment because of delinquency. There were no colored patients encountered in this survey.

In a census[1] by the U. S. Public Health Service in coöperation with the Ingham County Medical Society, of the genito-infectious disease cases actually under treatment from September 15, 1937, to January 15, 1938, there were 100 cases in the county as contrasted with 180 actually under treatment at the time of the present study. It was stated in 1938 that "the number of individuals found actually under observation and treatment exceeded by 40 per cent those who were reported to the State Health authorities."[1]

TABLE III. MODE OF DISCOVERY OF ACTIVE CLINIC AND PRIVATE CASES OF SYPHILIS
Ingham County Rural—June 1, 1940

Mode of discovery	Private		Clinic	
	Number	Percentage	Number	Percentage
Totals	125	100.0	55	100.00
Pre-nuptial	5	4.0		
Pre-natal	2	1.6		
Routine physical examination	43	34.4		
Diagnostic	74	59.2	55	100.0
Others	1	0.8		

Study of Table II shows that there were an equal number of men and women in this report. There was no major difference as to their distribution on a marital basis. The age distribution is interesting from the viewpoint of cases on record in the health department at the time of the study rather than as any evidence of actual incidence by age.

Classification of the 180 cases of syphilis according to their method of discovery as given in Table III, showed that all the clinic cases either had been referred there by private physicians or had come to the clinic on a suspicion, or knowledge, of their infection. The highest

percentage (59.2 per cent) of cases were discovered by bloods drawn for diagnostic purposes indicating a "high index of suspicion" on the part of the physicians.

gent consideration to the classification of their syphilis cases, but, on the other hand, it is our impression that Ingham County physicians are doing a better job than the average in this respect.

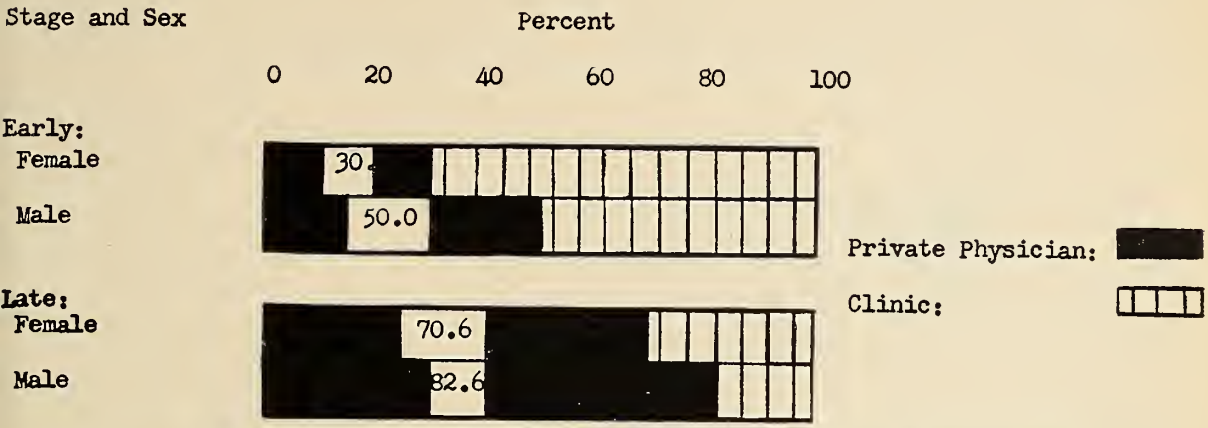


Fig. 1. Distribution of active private and clinic cases of syphilis by sex and reported stage of disease. Ingham County, Rural—June, 1940.

TABLE IV. NUMBER OF KNOWN INFECTED PERSONS IN THE SAME FAMILY IN THE ACTIVE PRIVATE AND CLINIC CASES
Ingham County Rural—June 1, 1940

Number of infected persons	Private		Clinic	
	Number of families	Percentage	Number of families	Percentage
Totals	107	100.0	42	100.0
One	91	85.0	32	76.2
Two	12	11.2	7	16.7
Three	4	3.7	1	2.4
Four			1	2.4

Table IV reveals that there was a somewhat higher percentage of one-person families under treatment with private physicians than in the clinic.

These 180 patients were next classified according to the stage of the disease on admission to service as given in Table V. There is no significant difference between the percentage of congenital cases treated by the private physicians and the clinic. However, 56.3 per cent of the clinic cases were early while 15.2 per cent of the private cases were in that category. Of the private group 52 per cent were late and 32.7 per cent of the clinic were late. The physicians classed twenty-six or 20.8 per cent of their patients as undetermined. Thus there is evidence that some private physicians are as yet not giving intelli-

TABLE V. NUMBER AND PERCENTAGE OF ACTIVE PRIVATE AND CLINIC CASES OF SYPHILIS BY REPORTED STAGE OF THE DISEASE
Ingham County Rural—June 1, 1940

Stage of disease	Private		Clinic	
	Number	Percentage	Number	Percentage
Totals	125	100.0	55	100.0
Congenital	15	12.0	6	10.9
Early:				
Primary	5	4.0	4	7.3
Secondary	3	2.4	10	18.2
Latent	11	8.8	17	30.9
Late:				
Latent	52	41.6	13	23.6
Neurosyphilis	7	5.6	5	9.1
Skin	2	1.6		
Bone	1	0.8		
Other Visceral	3	2.4		
Undetermined	26	20.8		

The high percentage of congenital syphilis should be noted. Herein lies a big problem for the medical profession and the health departments. Combining the two groups of figures reveals that 46.1 per cent of all the cases were late, 27.7 per cent early, 11.1 per cent congenital and 14.4 per cent undetermined.

Study of these figures on a sex basis as depicted in Figure 1 shows that more females with early syphilis were under treatment in the clinic than with private physicians, while the number of men with early syphilis was equally divided in both places. With late syphilis, over twice as many females were under treatment with the

private physicians as in the clinic and in the case of males the ratio was still greater. There was a total of sixty-nine males and fifty-six females under treatment with the private physicians, and four months from June, 1938, to June, 1940, and 50 per cent of the clinic cases during the same time. The private cases were treated an average of 16.8 months and the clinic

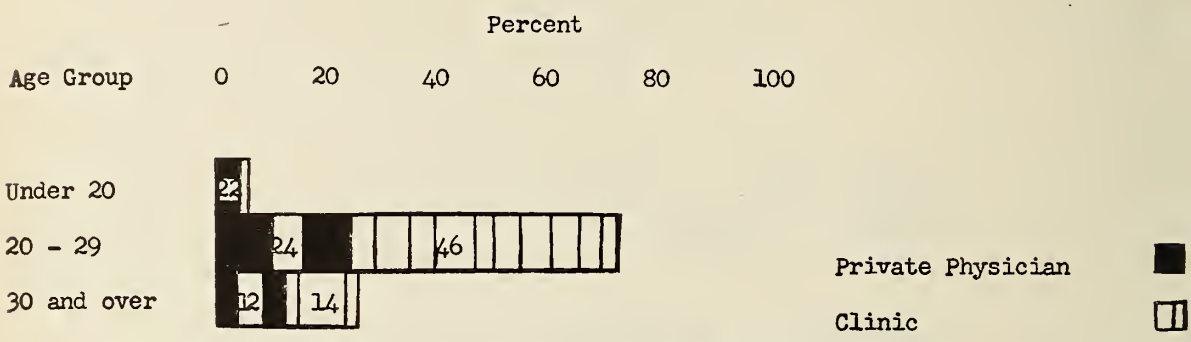


Fig. 2. Age distribution of early active private and clinic cases of syphilis. Ingham County, Rural—June, 1940.

twenty-one males and thirty-four females in the clinic. The total of those with early syphilis was thirty females and twenty males, and the total classified as late syphilis was thirty-four females and forty-nine males.

As shown in Figure 2, the greatest percentage of early cases were in the twenty to twenty-nine age group. The economic factor as related to this problem is evident in that nearly twice as many of this group were under treatment in the clinic as with the private physician. The percentage is nearly equal in those thirty and over. Under twenty there was only one early case each with the private physician and clinic.

The prevalence rate (constant patient population under treatment or observation) is 3.4 per 1,000 population as compared with the rate for early syphilis, which is 1.0. In 1938 these same rates for the county (including Lansing) were 3.8 and 1.2.[1] The 1940 census revealed the population of the county, exclusive of Lansing, to be 51,863.

The private cases were registered for a total of 2,665 months and the clinic cases for 1,445 months, giving a mean of 21.3 months in the former and 26.3 months in the latter. As shown in Table VI, 39.2 per cent of the private cases had been reported during the twelve-month period prior to June 1, 1940, while 18.1 per cent of the clinic cases were reported during the same length of time. Nearly 75 per cent of the private cases were reported in the twenty-

TABLE VI. NUMBER AND PERCENTAGE OF ACTIVE PRIVATE AND CLINIC CASES OF SYPHILIS REGISTERED AND TREATED DURING SPECIFIED PERIODS OF TIME
Ingham County Rural—June 1, 1940

Number Months	Registered				Treated			
	Private		Clinic		Private		Clinic	
	No.	%	No.	%	No.	%	No.	%
Totals	125	100.0	55	100.0	125	100.0	55	100.0
0					8	6.4		
1– 6	13	10.4	2	3.6	20	16.0	4	7.2
7–12	36	28.8	8	14.5	38	30.4	10	18.1
13–18	27	21.6	7	12.7	17	13.6	7	12.7
19–24	14	11.2	11	20.0	17	13.6	13	23.6
25–30	18	14.4	11	20.0	8	6.4	16	29.0
31–36	4	3.2	7	12.7	6	4.8	4	7.2
37–42	2	1.6	4	7.2	1	0.8	1	1.8
43–48	6	4.8	1	1.8	6	4.8		
49 and over	5	4.0	4	7.2	4	3.2		

cases 20.3 months. Eight, or 6.4 per cent of the private cases had received no treatment and had been reported from one to twenty-five months before the study began. Three of the cases had been reported twenty-five months before, one thirteen months, another ten, one six and two during May, 1940. All but one was the patient of a regularly licensed physician. The one was reported by an osteopath. The private physicians treated 46.4 per cent of the cases for twelve months or less and the clinic 25.3 per cent of their cases for a similar period. Seventy-

TABLE VII. AN ANALYSIS OF 133 CASES SHOWING TREATMENT GIVEN PATIENTS WITH EARLY AND LATE SYPHILIS BY PRIVATE PHYSICIANS AND CLINIC DURING INDICATED PERIODS OF TREATMENT

Ingham County Rural—June 1, 1940

Amount of Treatment	Period of Administration						Total	
	1–2 years		2–3 years		3 years or more			
	Early	Late	Early	Late	Early	Late	Early	Late
Private Physicians								
Oral only		3				3		6
Heavy metal only		5		1				6
Arsphenamine injections:*								
1–4		5				2		7
5–9	1	3					1	3
10–14		6				1		7
15–19	4	6				1	4	7
20 or more	11	14	2	4		4	13	22
unknown number	1			1			1	1
Total	17	42	2	6		11	19	65
Clinic								
Heavy metal only		1						1
Arsphenamine injections:*								
1–4								
5–9	1	3	1				2	3
10–14	1						1	
15–19	3	2		1			3	3
20 or more	14	4	11	6		1	25	11
Total	19	10	12	7		1	31	18

*The injections of arsphenamine are used as the index; the amount of interim heavy metal is not shown.

TABLE VIII. NUMBER AND PERCENTAGE OF ACTIVE PRIVATE AND CLINIC CASES OF SYPHILIS RECEIVING ARSPHENAMINE TREATMENT DURING SPECIFIED PERIODS

Ingham County Rural—June 1, 1940

Duration	Physicians					Clinic				
	1–19		20 or more		Ave. No. injections	1–19		20 or more		Ave. No. injections
	No.	%	No.	%		No.	%	No.	%	
Less than 1 yr.	32	25.6	9	7.2	14	8	14.5	2	3.6	13
1–2 years	8	6.4	28	22.4	28	4	7.3	15	27.2	25
2–3 years			9	7.2	45	1	1.8	19	34.5	31
3 or more	4	3.2	7	5.6	34	1	1.8	3	5.4	28
Total	44	35.2	53	42.2	30	14	25.4	39	70.7	24

TABLE IX. DURATION, NUMBER AND PERCENTAGE OF SINGLE LAPSES IN ACTIVE PRIVATE AND CLINIC CASES OF SYPHILIS

Ingham County Rural—June 1, 1940

Number of months elapsed	Private		Clinic	
	Number	Percentage	Number	Percentage
Totals	32	100.0	15	100.0
1–3	8	25.0	8	53.3
4–6	4	12.5	4	26.7
7–9	1	3.1	1	6.7
10–12	3	9.4		
13–15	5	15.6	1	6.7
16–18	2	6.2		
19–21	2	6.2		
22–24	4	12.5		
25–27	2	6.2		
28–30				
31–33			1	6.7
34–36	1	3.1		

three and six-tenths per cent of the physicians' cases received twenty-four months, or less, treatment, while 61.6 per cent of the clinic cases were treated for a corresponding length of time. The number of months registered per month treated was the same, 1.3.

It is interesting to compare Table VII with a similar one made in the 1938 survey[1] for the county as a whole. In Table VIII below, 133 cases are included, all of whom reside in the county exclusive of Lansing. In the similar study of 1938 there were included 125 cases, most of whom resided within the city of Lansing. The important point in this analysis is the marked increase of patients receiving better treatment in the first two years of the infection.

According to Table VIII the percentage of patients receiving twenty or more injections was nearly twice as great in the clinic as in the private offices. The average number of injections was somewhat lower in the clinic. In a number of instances the physicians when questioned on this point made a rough approximation as to the number they thought the patient had received without checking their records. As mentioned earlier there were eight who had not received any; eleven had received bismuth only; one mercury rubs and four oral medication. Two of the clinic cases had been treated with nothing but bismuth.

Table IX reveals that lapsed clinic cases are usually returned to treatment in shorter periods

TABLE X. NUMBER OF PATIENTS AND MONTHS INVOLVED IN SINGLE AND MULTIPLE LAPSES AMONG ACTIVE PRIVATE AND CLINIC CASES OF SYPHILIS

Ingham County Rural—June 1, 1940

Type of lapse	Private			Clinic		
	No. Pts.	No. Mos.	Average No. Mos.	No. Pts.	No. Mos.	Average No. Mos.
Single	32	404	12.6	15	93	6.2
Multiple	10	290	29.0	6	81	33.5
Total	42	694	16.5	21	174	8.3

of time than are lapsed cases in the hands of private physicians. This is undoubtedly due to the well-trained medical social case worker maintained in connection with the clinic. His services are also available to the private physicians.

The percentage of both groups of patients lapsing once is about the same, i.e., 25.6 per cent private cases and 27.2 per cent clinic cases. The same holds true with the total lapses, viz., 33.6 per cent of private cases and 38.1 per cent of clinic cases.

Table X gives another way of comparing lapses of clinic patients with those of the private cases. The multiple lapses occurred 2.6 times in the clinic and 3.1 times in the private cases. In the former patients 5.1 months were consumed with each lapse and 9.4 in the latter.

The only information as to economic status in this study is that the treatment of the county patients in the clinic is paid by Ingham County. In addition the county is paying the private physicians for the treatment of twenty-seven more. Also there are eight patients at the county infirmary being treated by a salaried physician. This gives a total of ninety, or 50 per cent of all the patients included in this study, whose treatments are financed by Ingham County.

Fifty-one of the 125 private cases were visited by one of the authors (L.E.K.) for the purpose of follow-up. In addition, as shown in Table X, there were twenty-one more cases in the clinic visited by the Medical Social Case Worker referred to above. Most of these 204 calls were for the purpose of stressing the need for continued treatment. At no time was any patient of a private physician visited unless this service was requested by the physician. Of this group thirty-eight returned for further anti-luetic therapy. The medical social case worker with the clinic made most of the calls on delinquent clinic cases located adjacent to Lansing. In the outlying districts one of the authors (L.E.K.) made the visits. Figure 3 shows the location of all active private and clinic cases in the county as of August 31, 1940. The discrepancy in dates is due to the fact that while the map was begun June 1, 1940, it was cumulative and it was the last of August, 1940, when the actual study was completed. Each square represents a square mile. It is quite apparent that the greatest concentration of cases is around the various municipalities but most particularly Lansing. The numbers within the squares represent the number of cases in that area.

After considerable research and discussion a four page form (copy on request) was adopted by the Ingham County Health Department as their permanent genito-infectious disease record. It is adaptable to use for any of the genito-infectious diseases. The information obtained from this form, if completed, is quite comparable to that available in clinics using a mechanical tabulating system.

Occasionally justification of the record was requested by the private physicians. The outstanding reason in our opinion was the transfer of full information relative to the status of the disease together with complete diagnostic and treatment records with the change of a patient from one physician to another, from a physician to the clinic or from our jurisdiction to that of another health department. There is the additional point which was not stressed with the physicians that the county has a right to full information on those cases for whom they are paying to assure themselves as a consumer of value received.

Upon receipt of a positive serological report the attending physician as indicated thereon was called by telephone or in person. In the former instance some discretion is necessary. At this time nearly all of the first page could be completed. It was usually suggested that if he so desired we would be glad to report the case to the State Health Department from this information thus saving him some slight trouble. Questions relative to the contacts as given on page 3 of the new record form served as a stimulus for further follow-up on the part of the physician. On a few occasions the health depart-

ment was requested to take over this task. All information secured on such visits, in addition to being recorded on our records, was turned over to the attending physician. By such means we were able to complete some case histories from an epidemiological point of view.

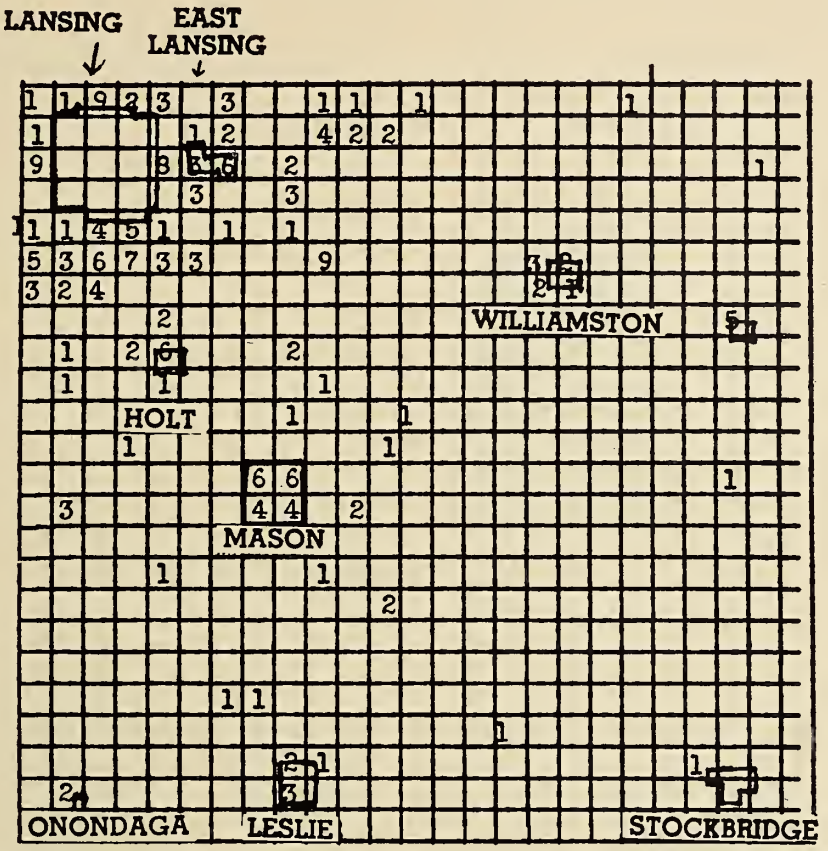


Fig. 3. Map showing location of active private and clinic cases of syphilis. Ingham County, Rural—June, 1940.

Such immediate action refuted the contention that reporting was meaningless because the health department did nothing about the matter. It was also felt that this procedure helped to improve the private physician-health department relations.

Maintenance of these records on a current basis can be accomplished by visiting the physician at least two times per year and preferably once every three months. If time permits this visit can also be utilized to good advantage in discussing other parts of the program and improving personal relationships.

These records were placed in manilla folders bearing the patient's name and filed alphabetically according to place of treatment, i.e., private physician or clinic. The only other distinction in filing was whether the case was active, i.e., under treatment or observation, or delinquent, or closed (discharged as cured, false positive, moved, unable to locate).

For obvious reasons this information was kept in a locked file to which only the director and his assistant had access.

For each record a 3x5-inch card, differently colored for the various diseases, was filled out as follows:

Name Our No. Family Folder No.
Reported Stage of Disease
Physician
Date Reported Date Infected
Source
Remarks:

These were filed alphabetically either as active or inactive. If they were placed in the latter category a notation under remarks was made as to the reason.

A system of colored flags gave other pertinent information, obviating the necessity of pulling the record on every occasion. One space on the

card was for the stage of the disease, another the location of treatment (clinic or physician) and whether the county was paying for treatment. The third space was to designate whether the case was discovered as a pre-natal or pre-marital, the feeling being that these two modes of discovery are the most important.

Suggested colors for the stages of the disease are: red—early; yellow—late; light blue—congenital and undetermined not flagged. There being fewer clinic than private cases, we indicated the former with a dark blue flag and the latter with none. A light green flag on a private physician's card denoted he was being paid by the county for treating the case. Dark green indicated the case was a pre-natal and orange that the infection was discovered on application for a marriage license. The remaining space can be used to designate other points as the need arises.

The letters FF in the upper right-hand corner indicated that a "family folder" had been made for some nursing service and that other history was available. On the nursing master file card the letters SF were a signal to the nurse to confer with the director regarding information in the "special file."

To aid in the quarterly visits to the doctors the cases were filed by physician. This was accomplished by means of a card for each doctor treating cases living in the county. On this card were placed only the names of each patient under his supervision. In the case of the clinic a copy of the monthly report from the central tabulating unit was forwarded to us along with a listing of the patients seen that month by the medical social case worker.

The following rules were endorsed by the venereal disease committee of the Ingham County Medical Society in their meeting of September 11, 1940. Upon recommendation of this committee the society accepted them at their September, 1940, meeting. The Contagious Disease Committee of the Ingham County Board of Supervisors later adopted the rules as their criterion of paying the private physicians. The rules read as follows:

The county will pay private physicians for treatment of cases of syphilis only in those instances where the individual cannot conveniently go to the Lansing City Clinic for such treatment. The following rules and conditions shall apply to all cases of syphilis for which Ingham County is responsible for medical care which are being treated in offices of private physicians.

Cases must be reported to the Health Department in accordance with state law and regulations.

The physician is to coöperate with the health officer in every way possible in securing facts from the patient which are pertinent to the case.

Specimens of blood are to be taken for laboratory analysis once each six months but not oftener.

A specimen of the spinal fluid is to be obtained within thirty days after the case comes to the attention of the physician or the health department except for cases in primary or secondary stage in which diagnosis has already been confirmed. The collection of all spinal fluids may be made in the Lansing City Clinic or Lansing City Hospital. The county will not pay for collection of routine spinal fluids in offices of private physicians or in private hospitals.

In cases of primary, or secondary, syphilis, and in other cases in which the spinal fluid has been collected in the early part of the treatment and found to be negative, the county will authorize payment for treatment not to exceed in number forty arsenicals given intravenously and forty heavy metals given intramuscularly. This number is inclusive of all of those which may have been given in any previous period by other physicians or clinics. After a maximum treatment of forty-forty, as indicated above, has been given, there shall be obtained another spinal fluid. If such fluid is found negative the case is to be dismissed from active treatment and no further medical care provided except on special request or for special reasons as may be determined by the health officer in consultation with a physician who is especially qualified in the treatment of syphilis. If the spinal fluid is found to be positive, consultation shall be requested to determine the advisability of giving treatment by hyperpyrexia or another treatment for central nervous syphilis. Any case to be given fever treatment, or other treatment of similar severity, shall be hospitalized under the direction of the local health department. Cost of such treatment will not be paid to private physicians.

Summary

During the summer of 1940 a survey was made of all the cases of syphilis reported to the Ingham County Health Department from April 1, 1938, to June 1, 1940, and all the cases of gonorrhea reported to them from January 1, 1940, to June 1, 1940. The latter group proved so small they were eliminated from the study. No colored patients were reported during either period.

1. The private physicians reported 168 cases and the clinic, eighty. Of the former only 3.5 per cent were not located while 11.1 per cent of the latter fell in that category.

2. A total of 180 luetic patients were included in the study, 125 under treatment and observation of seventy-one private physicians, and fifty-five supervised by the

Lansing City Clinic. Twenty-seven, or 21.6 per cent, of the private cases were not under treatment as of June 1, 1940. No clinic cases were thus classified.

3. There was an equal number of men and women with no significant difference as to marital status.

4. Twenty-seven and two-tenths per cent of all the cases were in the ten-year age group, twenty to twenty-nine. The greatest concentration of females was in this group. The highest number of males were in the forty- to forty-nine level.

5. All the clinic cases were discovered by means of a diagnostic blood test. More than half of the private cases were discovered the same way.

6. A higher percentage of one-person families were under the supervision of the private physicians than the clinic.

7. Fifty-six and three-tenths of the clinic and 15.2 per cent of the private cases were diagnosed as early on admission. Over half the private cases were late. Twenty and eight-tenths of the private and none of the clinic cases were undetermined as to stage of the disease.

8. The prevalence rate for early lues was 1.0 per 1,000 and for all cases 3.4.

9. The private cases were reported an average of 21.3 months and treated 16.8 months. The same figures for the clinic cases were 26.3 and 20.3 months.

10. The percentage of patients receiving less than nineteen injections of arsphenamine was less among the clinic than private cases. The percentage receiving twenty or more injections was nearly twice as great in the clinic as in the private offices.

11. The percentage of lapsed cases is about the same among both groups but the clinic lapses are shorter in duration and less frequent.

12. Fifty per cent of all the cases had the cost of their treatments defrayed by the county.

13. Follow-up visits were made on seventy-two of the 180 patients.

14. Procedures developed during the survey were:
   (a) The formulation of a satisfactory venereal disease record form.
   (b) Establishment of a card index.
   (c) Establishment of a set of rules for the payment of private physicians by Ingham County for the treatment of cases of syphilis.

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Suggested Inquiry Into Possible Relation Between Albuminuria, Essential Hypertension and Nutritional Deficiency

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▪ I wish to report certain observations of a very preliminary nature relating to the treatment on a nutritional basis of one group of individuals with albuminuria and another group with hypertension. There was no history or clinical evidence of acute or chronic nephritis or of any other pathology in any of the cases observed as far as could be determined. The type of albuminuria observed in these patients is hereafter referred to as adventitious albuminuria.

The treatment resulted in such marked improvement in most instances that we feel justified in reporting our experience, with the suggestion that a carefully controlled study be made of a large number of patients.

The treatment prescribed was essentially the same for both groups. It consisted of taking once or twice a day twelve to fourteen grams of dried brewer's yeast (one heaping teaspoonful) stirred in a half glass of water. No other medication was given.

Most of the hypertensive patients received two teaspoonfuls of yeast daily. They were also instructed to eat a well-balanced diet as outlined later in this report. This dietary regime was, however, not observed too well. The albuminuria patients received only one teaspoonful of brewer's yeast daily. They were not advised to change

their diet but were permitted to continue their usual eating habits.*

The value of brewer's yeast in the treatment of adventitious forms of albuminuria was discovered accidentally in connection with routine examinations for employment under a retirement system in which all new employes were required to pass a physical examination. I rejected a colored applicant because the urinalysis showed albumin and hyaline casts. He pleaded with me to give him further consideration and to tell him what he might do to correct this condition so he could qualify for employment. Since his diet appeared to be especially deficient in vitamin B, he was advised to take a heaping teaspoonful of brewer's yeast daily for one month and then report for a check-up. I was surprised to find that the albumin and casts had completely disappeared after one month. Subsequent urinalyses showed that the urine remained clear.

This led me to try the treatment on twenty other applicants for employment with this agency whose urinalysis showed albumin only or albumin and casts. At least two of them had a previous diagnosis of orthostatic albuminuria; one at a university health center where he was a former student. The majority of this group including those with a diagnosis of orthostatic albuminuria responded with the same results. The urine in all but four applicants became and remained clear of albumin and casts for the period in which they were kept under observation. Since they were not patients under my supervision it was not possible to re-examine the urine in most instances more than four or five times over a period of three or four months. I have no record of the exact ages of this group except that all of them were within the age limits of employable persons, namely twenty to forty years.

Some time later, after I had discontinued further attempts with the treatment of albuminuria, a male patient, about forty-five years, presented himself with a blood pressure of 200/110. The urinalysis showed a trace of albumin but no casts. There was no history or clinical evidence of nephritis. Because of the urinary findings he was placed on the prescribed dietary regime and advised to take a heaping teaspoonful of brewer's yeast twice a day supplemented with five milligrams of thiamin chloride, also twice a day. He continued at work as usual. I was surprised to find after one month of this regime that the blood pressure had dropped to 185/95. The urine was also free of albumin. Thinking that the first blood pressure reading might have been an error, I rechecked it repeatedly for several weeks and found that it gradually receded to 145/70. It has now been at this level for more than two years. The patient observes the dietary regime quite rigidly and continues to take brewer's yeast regularly.

This experience led me to try the brewer's yeast therapy on twelve hypertensive patients, with varying degrees of hypertension. The ages of this group varied from forty-five to seventy-six. Two of these patients also had anginal symptoms and received 10 mg. thiamin chloride daily in addition to yeast and the prescribed diet. The initial blood pressures taken on each individual, varied from 180/90 to 240/120. No extreme degree of obesity was encountered, hence there was no need for a reducing diet.

Nine patients responded favorably to the treatment. Some showed a dramatic reduction in blood pressure in two to four weeks. Others, particularly the older persons, responded more slowly. One woman, seventy-six years old, with a pressure of 240/120, did not show any improvement until after two months, when the pressure dropped quite suddenly to 185/95. It remained at that level for at least two months, after which circumstances made it impossible to continue further observation. None of these patients were required to take absolute rest. With one exception, they were all permitted to continue their usual activities. Rest was therefore not a factor in the treatment.

I also treated a few hypertensive patients with certain commercial vitamin B complex capsules but without apparent reduction in blood pressure. The same held true for thiamin chloride and nicotinic acid when given either separately or in combination.

Brewer's yeast is a valuable vitamin B complex and an important food. It has been used extensively in the treatment of pellagra and other vitamin B deficiencies. Its wide distribution in some of the southern states by the American Red Cross was primarily responsible for the marked

*Brewer's yeast may be given as a dry powder stirred in a half glass of cold water or it may be taken in tablet form. We have used the powder because it is easier to give an adequate dose that way. One heaping teaspoonful (12-14 grams) is equivalent to thirty-five or forty 5-grain tablets. It is more difficult to take that many or more tablets daily than one or two teaspoonfuls of the dried powder, stirred in water or some other fluid. Tomato juice is an excellent vehicle.

reduction in the pellagra death rate in recent years.[2] The results reported here lead me to believe that it may also be effective in the control of reno-vascular function in so far as this syndrome is influenced by nutrition. It may be that other foods, known to be rich in vitamin B factors, such as the whole of rice and wheat, are also useful for that purpose.

Brewer's yeast seems to be adequate by itself, without any alteration in the diet or additional medication to produce the results reported in this paper. However, if adventitious albuminuria and essential hypertension result from a nutritional deficiency, then we cannot expect permanent improvement unless these patients are also placed on a diet that provides all the factors necessary for the maintenance of buoyant health. It does not seem reasonable that yeast will be adequate by itself to maintain normal kidney function and vascular tension indefinitely. Other food factors may be equally important.

A well-balanced diet is, therefore, indicated in all instances where nutritional therapy is prescribed.

The diet outlined for the hypertensive patients is as follows:

1. Milk and dairy products; two glasses of milk daily; also butter or fortified margarine daily; some cheese regularly.
2. Fresh, uncooked fruit or their juices daily; oranges, grapefruit, tomatoes, and other fresh fruit in season.
3. Vegetables daily; at least two liberal servings other than potatoes. Leafy green (kale and turnip tops) and yellow vegetables are among the important ones. Some vegetables should be eaten raw.
4. Whole grain cereal products, daily; either as a breakfast food or bread, or both. Emphasis is placed on a cooked whole grain breakfast food as well as whole wheat bread.
5. One egg a day.
6. A moderate helping of meat once or twice daily. Beans and peas may be substituted for meat occasionally.
7. Sufficient water and other fluids—five to ten glasses daily.
8. Highly refined white flour products, refined sugars and candies should be eaten sparingly.
9. Unrestricted use of salt.

The total quantity of food consumed, measured in calories, should be gauged largely by the weight of the individual. It is better to under-eat a little than to over-eat.

These two group experiences are reported simultaneously because both seem to be amenable to the same form of nutritional therapy and because there is good evidence that hypertension is due to a humoral mechanism of renal origin. This thesis has been ably demonstrated by Page et al; Corcoran and Goldblatt.[1,3,4] It is possible that this humoral mechanism is indicative of a vitamin or other nutritional deficiency, with particular reference to the kidneys. An insidious rise of blood pressure, if not related to nephritis, may be caused by a gradually failing renal function, even though albumin is not detected by ordinary methods of testing. Other methods of measuring renal function nutritionally may be developed. It is difficult to explain the sharp fall in blood pressure after so short a period of nutritional therapy unless it is related to renal function. It does not seem reasonable that any material change in the arterial system, *per se,* could occur so rapidly. It seems quite credible that a failing kidney function would respond quickly to appropriate vitamin therapy in the same manner that cardiac function in beriberi often improves dramatically with the administration of an adequate amount of thiamin; and mental derangement in pellagra to the administration of nicotinic acid. An abnormal vascular tension may be suddenly relieved when normal kidney function is restored.

Essential hypertension may be a passive condition bearing the same relation to renal function that a fixed hypertension bears to fixed renal pathology. It may also be possible that such a passive hypertension may eventually become fixed if adequate nutrition is neglected and renal pathology has advanced to a stage when it can no longer be corrected by any form or therapy.

All this is, of course, theoretical and can be determined only by carefully controlled studies. If further investigations should prove beyond reasonable doubt that essential hypertension is the result of renal failure, then all adventitious forms of albuminuria deserve more careful consideration in our diagnostic and therapeutic procedures.

These observations, even though of an empirical nature, would seem to call for nutritional studies of a large group of patients with essential hypertension and another group with adventitious forms of albuminuria. These studies might clarify the connection between hypertension and albuminuria. If it is found that nutrition plays a role in this reno-vascular syndrome, then these studies

should also be extended to cardiac, cerebral and other disease manifestations frequently associated with hypertension. No cardiac studies were made in any of this group of hypertensive patients but at least one with symptoms of angina was completely relieved after three months of treatment.

We are not making any positive claims in this paper but only reporting our experience and offering suggestions for a detailed and controlled study. Our observations may not be correct or they may have to be modified. The truth will not be known until such controlled studies are carried out.

Summary

A small group of individuals with essential hypertension and another group with adventitious albuminuria were treated successfully with dried brewer's yeast. The treatment was essentially the same for both groups.

There appears to be a definite relation between essential hypertension and a gradually failing renal function.

This report seems to justify carefully controlled studies of larger groups to determine whether renal failure results from faulty nutrition and how hypertension is related to it.

If it is found that nutrition plays an important role in this syndrome and related disease manifestations, then it must also be determined what nutritional factors have such significant health values.

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MSMS

We must help to develop a means for assurance of medical service to those of our citizens who need it, and who cannot otherwise obtain it.

This is a task that must be carried out in co-operation with our medical men. There can be no group better able to advise on medical care than the medical profession.

Yet, unhappily, this is the very group which the New Deal has managed to alienate.

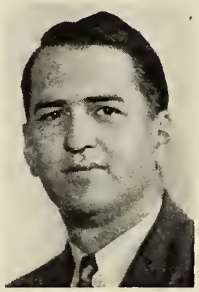
Our free and independent medical profession has advanced medical science in America ahead of every other nation in the world. Its freedom has made it great. It should be encouraged, not discouraged.

Let us enlist the leadership and aid of the doctors of America in organizing our private and public hospitals as well as our other services into a fully effective system to protect the health of all our people.—Gov. T. E. Dewey's Statement of Policy.

Tubal Pregnancy

Unusual Occurrence of Seven Cases in One Year of General Surgical Practice

By John M. Sisson, M.D.
Detroit, Michigan



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■ THE following is a review of the salient points in seven cases of tubal pregnancy operated upon during March 1943 to March 1944. An effort is made to clarify the more important factors in the history and physical examination in order to facilitate early diagnosis in this condition.

Certain points stand out in the following cases which point definitely toward the diagnosis of tubal pregnancy before finding blood in the abdomen.

Presentation of Cases

Tubal Abortion

Case 1.—Mrs. M. G., aged thirty-five, three full-term pregnancies; no abnormal pregnancies. Menses, began at age fourteen, twenty-nine day cycle, duration three days, moderate, slightly irregular past year. Admitted March 24, 1943; operated upon March 24; discharged April 3, 1943. Complaint—pain in lower abdomen for three days.

The last menstrual period was January 28. The patient was well until March 21, when she developed cramp-like pains in the lower abdomen for a short time. Pain recurred on March 23 more severely and was associated with nausea and vomiting and generalized abdominal pain. Bowels were regular; there was moderate leukorrhea for the past three months intermittently. No previous nausea or breast signs. No history suggestive of pelvic inflammatory disease or puerperal infection. This patient was first seen after admission to hospital with provisional diagnosis of acute appendicitis. Examination revealed blood pressure 115/80, pulse 96, temperature 99.2, respirations 20. Laboratory findings: red blood cells 3.64, white blood cells 6,500, hemoglobin 10.6, polymorphonuclears 71, lymphocytes 24, 7 stabs, 5 mononuclears.

From Mt. Carmel Mercy Hospital Surgical Service.

Examination revealed localized pain and tenderness over right lower quadrant and marked muscular spasm across entire lower abdomen. Extreme pain and tenderness was left in right adnexa on manipulation of cervix with very tender mass in right adnexa. Uterus was slightly enlarged; no bloody or abnormal discharge.

Operation—On March 24, 1943 laparotomy revealed moderate amount of free and clotted blood in abdomen. Right tube was found greatly enlarged and bleeding slowly from fimbriated end. The entire mass was adherent to surrounding structures by recent adhesions. The tube was removed. A simple corpus luteum cyst on left ovary was ruptured and the appendix removed.

Pathological Report.—Uterine tube 5.5 cm. in length. The fimbriated end was distended to 4 cm. in diameter. A chorionic vesicle with intact fetus approximately 1.5 cm. in length protruded from the fimbriated end. The vesicle was surrounded by a blood clot. The remainder of the tube was hyperemic.

Microscopic examination revealed a placental site. Chorionic villi were well preserved and vascularized. There was decidual reaction in the walls of the tube.

Diagnosis.—Tubal pregnancy with tubal abortion.

Postoperative Course.—Uneventful recovery.

Case 2.—Mrs. R. F., aged twenty-eight, had had one normal pregnancy eight years ago. Menses onset at age thirteen, twenty-eight day cycle, duration four days, regular, painless, moderate.

Admitted April 20, 1943; operated upon April 21; discharged May 1, 1943. Complaint—pain in the lower abdomen.

The last regular period started February 20, 1943, but on March 17 the patient started spotting and having pains across the lower abdomen. Both spotting and pain persisted and pain had become quite severe. No nausea or breast signs. Weakness and faintness for the past two days.

When first seen on April 19, 1943, examination of the patient revealed temperature 99.6, pulse 90, hemoglobin 80 per cent, dark bloody vaginal discharge, extreme pain on touching cervix, marked tenderness and questionable mass in left adnexa. Tenderness and muscle spasm over both lower quadrants.

On April 21, 1944, temperature 98, pulse 84, respiration 18, hemoglobin 10.8 gr, red blood cells 3.87, white blood cells 6,950, polymorphonuclears 61, lymphocytes 33, basophils 1, stabs 14, mononuclears 5.

Operation—On April 21, 1944, dilitation and curettage were first done to rule out incomplete abortion. No products of pregnancy were found.

Laparotomy revealed free blood and clots. The left tube was found to be greatly distended in its midportion, apparently containing products of early pregnancy. The tube was removed.

Pathological Report—(1) Curettings revealed secretory endometrium. (2) Uterine tube measured 6 cm. in length. The ampullary portion was distended to 2.5 cm. diameter. The serosa was dull, opaque and hyperemic. The distention of the tube was due to the presence of a large mass of clotted blood which had not ruptured through the tube. Sections through the mass revealed the presence of chorionic villi and a placental site. Fetal parts were not found.

Diagnosis.—Tubal abortion.

Postoperative Course—One transfusion, 500 c.c. whole blood given. Recovery uneventful.

Tubal Pregnancy

Case 3.—Mrs. J. G., aged twenty-eight, one full-term pregnancy, five years ago. No miscarriages; menses onset at age thirteen, twenty-eight day cycle, duration four days, moderate dysmenorrhea.

Admitted May 7, 1943; operated upon, May 8; discharged May 17. Complaint—pain in right lower quadrant of the abdomen.

Last menstrual period April 4, 1943. On April 15 she complained of mild pains in the lower abdomen which persisted, accompanied by moderate leukorrhea. On May 1 when her period was due she started menstruating a small amount and this had persisted. On May 6 she developed rather severe pain in the right lower quadrant, followed by faintness. No nausea or vomiting; no history of miscarriage or pelvic inflammatory disease. Although separated from her husband, she admitted sexual relations. She stated that she had left tube and appendix removed four years ago.

Examination revealed tenderness, muscular spasm in right lower quadrant of the abdomen.

There was a slight bloody discharge, extreme pain in right adnexa on manipulation of cervix, tenderness in right adnexa. Pulse 84, temperature 98.2, respiration 20, red blood cells 3.82, white blood cells 10,900, hemoglobin 11.6, polymorphonuclears 42, lymphocytes 45, 8 eosinophils, 10 stabs, 5 mononuclears.

Operation.—Upon laparotomy a small amount of free and clotted blood was found in the abdomen. The uterus was slightly enlarged and soft. The left tube was normal. The right tube was greatly distended and clotted blood protruded from the fimbriated end. The right tube was removed. Appendix was found to be retrocecal and normal in appearance, so it was not removed.

Pathological Report.—The uterine tube was approximately 7 cm. in length. It was from 1 to 2 cm. in diameter. The serosa was cyanotic and hyperemic. There was a small blood clot at the fimbriated extremity. A serosal cyst approximately 1x4 cm. appeared near the fimbriated end. This contained clear fluid. The lumen contained blood clots in its entire length. Small masses of pinkish-white tissue were found within the clots near the fimbriated extremity.

Microscopic examination showed the material within the lumen contained masses of chorionic villi and decidua.

Diagnosis.—Tubal pregnancy.

Postoperative Course.—Uneventful recovery.

Ruptured Tubal Pregnancy

Case 4.—Mrs. C. M., aged thirty-four, two full-term pregnancies; no miscarriages; menses onset at age

thirteen, twenty-eight day cycle, duration five days, regular, painful.

Admitted July 23, 1943; operated upon July 24; discharged August 4. Complaint—pain in lower abdomen.

Last menstrual period June 24, 1943. The patient stated she was well until July 2, 1943, when she had a severe attack of lower abdominal pain and fainted. Pain lasted two hours, but recurred the next day and there had been persistent pain and soreness in the lower abdomen ever since, but no bleeding. She was first seen on July 23 and was found lying in bed acutely ill, feeling faint and weak and complaining of moderate lower abdominal pain. No nausea or vomiting. Examination revealed moderate muscular rigidity across entire lower abdomen with marked tenderness, especially on left side.

The uterus was normal in size. There was marked pain in the left adnexa on manipulation of the cervix and tender mass in the left adnexa. Pulse 90, temperature 98.6, respiration 18, blood pressure 100/80.

Upon admission to the hospital, laboratory findings were: red blood cells 3.01, white blood cells 5.100, hemoglobin 10, polymorphonuclears 67, lymphocytes 29, stabs 7, mononuclears 4, slight hypochromosis.

Operation revealed moderate amount of free and clotted blood. A large mass of clotted blood was found protruding from the left tube near the fimbriated end. The tube was greatly dilated. The tube was removed in routine manner. Recovery was uneventful.

Pathological specimen consisted of a markedly distended uterine tube 6 cm. in length. The midportion of the lumen was 2 cm. in diameter and a large blood clot was seen attached to the distal end of the tube. There was a rupture of tube near the fimbriated end. The serosa was edematous and hyperemic. The lumen was filled with clots and fragments of whitish tissue.

Microscopic examination showed chorionic villi and decidual tissue are identified in the section.

Diagnosis.—Ruptured tubal pregnancy.

Case 5.—Mrs. M. M., aged thirty-three, one miscarriage at three months four years ago. No other pregnancies. Menses began at age thirteen, twenty-seven day cycle, duration four days, moderate, painless, regular.

Admitted August 4, 1943; operated upon August 4; discharged August 13. Complaint—severe abdominal pain.

Last menstrual period started June 12, 1943 and regular. The patient was well until July 13, 1943 when she started to spot and have mild cramp-like pains and soreness in the lower abdomen, which persisted until August 3, when she developed a sudden knife-like pain in the lower abdomen, fainted and developed nausea and vomiting. She was seen by a physician who diagnosed ptomaine poisoning and prescribed one ounce of castor oil, which was taken. Pain, vomiting and faintness persisted, and on the morning of August 4 she repeated the dose of castor oil. When first seen, one hour before admission, she was lying in bed covered with perspiration, very pale and complaining of severe lower abdominal pain. The abdomen was moderately distended with marked tenderness and rigidity across both quadrants. Vaginal examination revealed a moderate bloody discharge, extreme pain on manipulation of cervix and extreme tenderness in left adnexa. Blood pressure was 70/40, pulse 130, respirations 26, temperature 99.4.

She was transferred quickly to the hospital and sent directly to the operating room where she was given 500 c.c. of plasma while being prepared for laparotomy and blood count and typing. Blood pressure could not be determined at first, but gradually came up to 80/60 after administration of about 200 c.c. of a 500 c.c. transfusion of whole blood. On admission pulse was 104, temperature 99.2, respiration 20, red blood cells 2.34, white blood cells 16,100, hemoglobin 7.2, polymorphonuclears 93, lymphocytes 7.

Operation was performed very quickly without anesthetic, due to the poor condition of the patient, who was only semi-conscious. Oxygen was given throughout the operation. A large quantity of fresh and clotted blood was encountered in the abdomen. The left tube was found to be ruptured and bleeding profusely. The tube was quickly removed and the abdomen closed without drainage, and no attempt was made to remove free and clotted blood.

On the first postoperative day, transfusion of 1000 c.c. of blood cells in saline was given and the patient made an uneventful recovery.

Pathological specimen consisted of uterine tube 5 cm. in length with a maximum diameter of 1 cm. There was a rupture of the tube in its midportion, and the lumen at this point was obliterated by white tissue.

Microscopic examination showed blood clots containing masses of chorionic villi from an early pregnancy. Section through the tube revealed the point of rupture. There was a decidual reaction at this site.

Diagnosis.—Ruptured tubal pregnancy.

Case 6.—Mrs. M. J., aged twenty-eight, one normal pregnancy two years ago, menses began at age fourteen, twenty-six day cycle, duration three days, often irregular, painless, moderate.

Admitted December 24, 1943; operated upon December 27; discharged January 5, 1944. Complaint—persistent pain in right lower abdomen.

Starting four days before admission, the patient developed acute pain of moderate severity associated with faintness, in the right lower abdomen. Bowel habit was normal. She had some nausea, vomited once and was seen by the doctor two days later. Last menstrual period onset November 14, 1943, no nausea or breast signs. Examination at that time revealed the following findings: pulse 110, temperature 98.4, hemoglobin 86, white blood cells 11,650, blood pressure 110/80. There was slight bloody dark discharge from the cervix, pain in right lower quadrant upon moving cervix, extreme tenderness in right adnexa. Uterus was normal in size.

Diagnosis.—Possible ectopic pregnancy.

After two days' rest, the patient was again seen and still complained of pain, had brown discharge, tenderness and suggestion of a mass in the right adnexa. Pulse was 120, temperature 98.8, blood pressure 110/80, white blood cells 8,500, hemoglobin 84.

She was then sent to the hospital. Upon admission, a Friedman test was ordered and routine laboratory tests showed red blood cells 3,960,000, hemoglobin 10.8, white blood cells 5,900, polymorphonuclears 80, lymphocytes 20, urine 3 to 5 wbcs. On December 27 red blood cell count was 3,780,000, hemogobin 11.4, white blood cells 5,900, polymorphonuclears 65, lymphocytes 35. Friedman test was positive.

The pain and bloody discharge had persisted, so on December 27 operation was performed. A moderate amount of clotted and free blood was found in the abdomen and the right tube was distended to 4 cm. in diameter and clotted blood was protruding from near the fimbriated end. The right tube was removed. The uterus was slightly enlarged and soft. No other pathologic changes were found.

Pathological Report.—The specimen consisted of the right tube measuring 7 cm. in length. The fimbrial markings were not well preserved. The serosa was rough and edematous and covered with fibrous tags. The central portion was dilated to 4 cm. in diameter and at this point there was a rupture through which protruded a large hemorrhagic mass measuring 4.5 x 3.5 x 2 cm.

Microscopic examination revealed the hemorrhagic mass to contain clumps of chorionic villi from a very early pregnancy. The wall of the tube was edematous and infiltrated with lymphocytes.

Diagnosis.—Right ruptured tubal pregnancy.

Postoperative Course.—Uneventful recovery.

Case 7.—Mrs. E. S., aged twenty-two had two children.

Admitted March 4, 1944; operated upon March 4; discharged March 15.

Last menstrual period onset December 28, 1943. On February 11, 1944 gradual onset of right lower quadrant pain with residual soreness. On February 18 and 23 there was slight spotting. Bowels were regular, with some nausea. The patient was seen on February 25. Her condition was diagnosed as possible ectopic pregnancy and she was kept under observation.

She developed severe right lower quadrant pain at 2:30 A.M. on March 4 and started flowing again. Pain persisted, with some faintness. There was no history of pelvic inflammatory disease or puerperal infection. The youngest child was three years old.

Abdominal scaphoid, very tender in right lower quadrant, with moderate rigidity. There was a dark bloody discharge, and the uterus was slightly enlarged. The right adnexa was very tender upon manipulation of the cervix, with a questionable mass. Blood pressure was 100/64, temperature 99, pulse 96, respiration 18.

Operation.—A low midline incision was made, and about 500 c.c. clotted and free blood was found in the pelvis. The right tube was found to be greatly distended, being about 4.5 cm. in diameter throughout the distal three-fourths of its length. Clotted blood was protruding from the fimbriated end. There were numerous adhesions between the uterus, tubes and omentum. These were ligated and divided. The left tube was found to be adherent to the ovary and broad ligament and was almost obliterated. It was left intact. The right tube was removed with the contained products of conception. The appendix was removed.

Pathological Report.—The appendix measured 5 cm. in length. The serosa was smooth and shiny. The lumen was continuous throughout and contained fecal material. Also submitted was the right tube which was 10 x 4 cm. in thickness. The serosa was rough and edematous and was covered with fibrous tags in some areas; it was deeply injected in others. The fimbrial markings were fairly well preserved. Serial sections revealed it to contain an ectopic pregnancy, decidua, and placental tissue.

Microscopic examination showed small lymphocytic accumulations in the serosa of the appendix and occasion eosinophil leukocytes on the surface. Sections from the tube revealed hemorrhagic extravasation. The lumen contained masses of early chorionic villi.

Diagnosis.—Peri-appendicitis—tubal pregnancy.

Summary

1. Pain in lower abdomen starting after delayed or missed period, usually persistent and progressive—becoming severe when rupture or tubal abortion occurs.

2. History of previous pregnancy followed by a period of no pregnancies for a variable length of time. No evidence of previous pelvic inflammatory disease found in this series, except in one case.

3. Vaginal bleeding in most cases, of irregular amount. May start at time regular period is due and thus confuse the picture.

4. Pelvic examination—extreme pain on manipulation of cervix—more marked upon side involved. Usually a mass may be palpated in adnexa of side involved.

5. Abdominal examination — tenderness and varying muscle spasm, depending largely upon amount of blood in abdomen.

6. Laboratory findings—Slight or moderate fall in red blood cells and hemoglobin unless rupture with profuse bleeding, as in Case 5. Normal or slightly increased white blood cells.

7. Miscellaneous—pulse slightly elevated, temperature normal or slightly elevated. Blood pressure normal unless hemorrhage is severe.

Conclusion

Many more of these cases can be diagnosed pre-operatively if a careful history is taken and careful examination done.

Many patients with a small rupture or a tubal abortion probably recover spontaneously.

Only a few patients bleed profusely enough to require immediate surgical intervention.

Resolution Re Dr. Andrew P. Biddle

WHEREAS, This Society has suffered the grievous loss of its most beloved member, counselor, and friend, that Patron of Postgraduate education in medicine, Doctor Andrew Porter Biddle, and

WHEREAS, This Society desires to recognize his outstanding contribution to the advancement of education, both lay and medical, and his manifold services to his profession, his city and his country, and

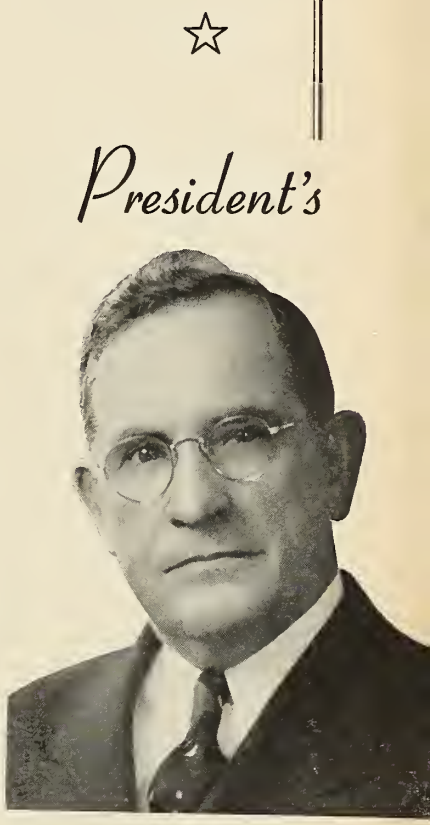
WHEREAS, For more than half a century he gave untiring and devoted services to this Society as Secretary, Editor, and founder of its Journal, and

WHEREAS, He served as President for two successive terms, and as member of the House of Delegates and as Councilor over many years, where he exerted an influence exceptionally fine, always in the interest of the highest ethical and moral standard; therefore

BE IT RESOLVED, That the Michigan State Medical Society, in Annual Session at Grand Rapids, September 27, 1944, record the debt that organized medicine owes to Doctor Andrew Porter Biddle for his inspiring influence, and its appreciation of his constant interest in postgraduate medical education, an interest which found concrete expression in a liberal bequest to the used in carrying on this work; therefore

BE IT FURTHER RESOLVED, That this resolution be made a permanent part of the written history of the Michigan State Medical Society.

Great Principles Must Be Fought For —to Be Preserved!



President's Page

I assume the office of President of the Michigan State Medical Society with humility and thanks. I realize the great responsibilities of this position and know that, alone, I would not be able to carry through. But realizing the ability of the membership of our organization—you who have appointed me to the presidency—I take courage and begin the year's important work with confidence. I am grateful for the honor you have bestowed upon me. I beg your continued help and guidance in the affairs of our Society.

In my brief address to the House of Delegates last month in Grand Rapids, I stated that certain influences and powers in this country are attempting to change the great principles which govern medicine today—they would throw away all vestige of the tenets upon which medicine is founded and substitute in their stead the dictum of compulsory rule. The great principles behind medicine must be fought for to be preserved. Like the present global conflict that surrounds us and touches all our lives, our medical fight may prove to be costly, but it will be a worthy one. We shall be fighting for the preservation of principles not alone for ourselves but for those who follow us in medicine.

Awake, Doctors, and know what is going on about you! Realize the powerful, the real attacks being made upon you and your profession. Turn the enemy's sword with the shield of truth—spreading to the people your knowledge of medicine and its accomplishments. Give them the facts. Give them service in abundance. Give them your best in medicine. Show them by your actions that only a free science, unchained and untrammeled, can soar to greater heights. Prove to them that this is what they want and is part of that which they hold dear—Freedom under Democracy.

A. S. Brunk

President, Michigan State Medical Society

EDITORIAL

DOCTORS FOR THE FUTURE

■ Enough medical men for postwar civilian practice is a problem demanding immediate attention. Congressman L. E. Miller, Missouri, recently introduced a bill to correct the situation. Here is another object lesson of the viciousness of bureaucratic controls. Selective Service and the armed forces have decided, the President approving, by refusing to take action, that boys of premedical student age and inclinations are of more use to the people of the United States as buck privates, now, than as Doctors of Medicine in the postwar period when only females and 4F's will still be in school.

Bureaucracy, Gen. Hershey, Paul McNutt, and the President tell us there will be medical men now in the armed forces returning to civilian practice in sufficient numbers to fill the vacant places. Manifestly that cannot be true for several reasons. First, the ranks of civilian doctors is fast thinning. The death rate among them as reported at the American Medical Association House of Delegates meeting in Chicago is much higher than for the past several years. About half of the deaths are from heart and vascular disease, with coronary disease approximately half of these. More vacancies will have to be filled than under normal conditions. Industrial surgery will and already has, increased the demands for doctors of medicine.

Secondly, our numerous armies stationed in far off regions to police the world will keep their medical officers with them. The world, and especially its war-torn districts, will be in woeful need of medical skill and no other nation is able to furnish the men to do the work. That will account for other thousands of Doctors of Medicine who will not be available for civilian practice.

Thirdly, the so-called GI Bill of Rights, which we discussed last month, provides for five hundred million dollars worth of new hospitals for the use of ex-servicemen, which is more than two $5,000,000.00 hospitals for each state. Those hospitals will absorb many doctors, and it is provided in the law that medical officers may be transferred from the army or the navy to Veterans' Service for six months after the termination of the war.

Lastly, it will be physically impossible to return military personnel from overseas service at a rate much greater than a quarter of a million a month, which will make return to civilian practice a rather long drawnout affair.

Doctors who have retired or who are aged, are now doing vastly more work than they should, or would under ordinary circumstances, and the result is shown in death reports. In the *Journal of the American Medical Association* for August 12, 1944, seventy-eight deaths are reported. Six deaths were among the men in military service, with one from coronary occlusion and one from chronic myocarditis. But among the seventy-two civilians there were seventeen deaths from coronary heart disease, and thirty-two from other heart and vascular diseases. Twenty-three per cent of deaths were from coronary disease, and forty-four per cent from other heart and vascular diseases. All other causes of death accounted for thirty-three per cent.

Some persons have been inclined to criticize the civilian doctor who apparently is not rendering his services to the armed forces, but in view of these facts, that criticism is hardly well founded. One thing the doctors on the home front must remember: if they are to continue their services among the families of our fighting men, among our war workers, and among the public in general, *they must look more carefully after their own health.* Most of them are working to actual exhaustion, and that must not continue. Time for relaxation must be found, or we will have even greater need to worry over where the medical students of the future will be found. More premedical students MUST be provided at once.

Every one of us should urge the passage of Congressman Miller's bill, H.R. 5027, which orders Selective Service to defer at least six thousand men for premedical studies, and four thousand for dentistry. These figures are an absolute minimum to barely maintain the numbers needed now for replacements of natural losses in

the professions. More doctors will still be needed to supply the added calls for the care of industrial workers. The health of the nation demands attention NOW.—Inform your senators and congressmen of your wishes.

POLITICAL MEDICINE

■ The American Legion, Department of Michigan, at its annual meeting in Grand Rapids in August, we are informed passed a resolution condemning the Wagner-Murray-Dingell Bill. We congratulate the Legion on its action. Recently that bill has been ignored in these pages, not because we deem it innocuous, but because we have been trying to point the finger to what is really of more importance to the health and welfare of the nation. We as physicians CAN operate under Wagner-Murray-Dingell controls much better than can the health of the public. But emphasis has been turned to other modes of encroachment of the government into control of medical practice.

This summer a rather startling attack has been launched, one that has more of a chance to pass than legislative action. The proposed amendment to the Constitution of the State of Michigan by referendum is vicious. All that is needed is 120,000 signatures to the petition, and it goes upon the ballot. It *could be passed* for it ostensibly offers much to the man groping for help. The fact that there are not enough doctors, dentists, nurses, or hospitals to service the scheme makes no difference to its proponents. This measure unwisely puts regulations, salaries, and all sorts of arrangements into the constitution of the state, the fundamental law of the commonwealth. Changes in regulations, or salaries are bound to be needed, and could not be made short of an amendment to the constitution. This feature alone may prove to be the unworkable restraint that will lead to disaster.

The amendment gives complete medical, surgical, obstetrical, dental, nursing, hospital and pharmaceutical care to all "normal" citizens of the state and their dependants. All that will be necessary is to call the doctor. An outline of the provisions was published in the August JOURNAL, page 632. This proposal provides far more than Wagner-Murray-Dingell, and cannot function satisfactorily. But why risk the health and well-being of our state to find that out?

Michigan Medical Service and its proposed increase of function will supply the bulk of the emergency care to all those inclined to insure against medical emergency. The indigents have always been a public problem, and will so continue. But why put everyone on that sort of care, making them subject to such inadequate arrangements as inexperienced bureaucrats may be able to offer?

This proposed amendment merits our united opposition. It is against public interest and health.

WE STILL NEED A BOOK

■ A letter was read to the Executive Committee of the Council at its August meeting asking for information. A junior medical student asked his father why more effort is not being made to place information before groups of medical students. He complained that these students get plenty of propaganda favorable to state medicine, bureaucratic practice, group practice, salaried positions, but none about the ideals and privileges of private practice. The ethics and economies of medical life and practice are learned only incidentally, and haphazardly.

The book we suggested several months ago has attracted the attention of others and efforts are being made to sound the possibilities. We admit the writing of such a book is a labor of no small proportions, but we submit that that work is seriously needed, and will be forthcoming. This query from a junior medical student shows one phase of the need. It also shows a defect in our medical courses that has been apparent for decades. Many times it has been suggested that some well-informed private practitioner of medicine be chosen to give a course of lectures on problems of medical practice, relations to patients, finance and medical ideals at our medical schools, elective, if thought best, but one that all the students would be invited to attend. Sporadic attempts have been made but not continued.

This *book* could be so written that it would serve as a text in such a course and would be available for reference to inquiring students in medical and sociological fields, who are asking for the medical side of socialized or state medicine.

Yes, we need a book—NOW!

PRESIDENT

■ Andrew S. Brunk, M.D., of Detroit is President of the Michigan State Medical Society. He was inducted into office September 27, 1944, having been elected at the 1943 Sessions. Dr. Brunk has served the Society well and faithfully over a period of many years, both as an officer of the Wayne County Medical Society and as Councilor and Chairman of the Council of the Michigan State Medical Society. He has succeeded to the presidency at a time of particular stress, with prodigious problems to be met and solved, but his apprenticeship has been gruelling, and his administration will be of the finest.



ANDREW S. BRUNK
President



VERNOR M. MOORE
President-Elect



DEAN W. MYERS
Councilor, Fourteenth District



A. B. SMITH
Councilor, Fifth District

PRESIDENT-ELECT

■ Vernor Milo Moore, M.D., of Grand Rapids is President-Elect. His election was unanimous, testifying to the high esteem in which he is held by his confrères. Dr. Moore served his Kent County Medical Society in many capacities, including the presidency. In 1935 he was appointed to the Council of the Michigan State Medical Society, where his service was immediately assigned to the Finance Committee, of which he soon became chairman, and also a member of the Executive Committee. He has served a year as Chairman of the Council. Dr. Moore has been a member of the Board of Trustees of Michigan Medical Service since its inception. He is a roentgenologist by practice, enjoying the complete confidence and support of his profession in scientific affairs as well as administrative. We bespeak for him a satisfying term of office.

COUNCIL

■ Dean W. Myers, M.D., of Ann Arbor was re-elected as Councilor of the Fourteenth District. He has served out the term of Dr. L. J. Johnson who went into military service.

A. B. Smith, M.D., of Grand Rapids was elected to the position of Councilor of the Fifth District, to the vacancy caused by the elevation of Councilor Moore. Dr. Smith has long been practicing in Grand Rapids in association with former President Corbus. He served in the first World War as a Captain, later as Major, in France, where he served with distinction and credit.

OTHER ELECTIONS

■ P. L. Ledwidge, M.D., of Detroit was re-elected Speaker of the House of Delegates in testimony to his outstanding service in a trying position. He has labored in season and out at this job with all its multitudinous duties.

Ellery A. Oakes, M.D., of Manistee was re-elected Vice Speaker of the House of Delegates. He is an able presiding officer.

Henry A. Luce, M.D., of Detroit, C. R. Keyport, M.D., of Grayling, and T. K. Gruber, M.D. of Eloise were re-elected as Delegates of this Society to the House of Delegates of the American Medical Association. Their services in that body have been long and active.

Alternates re-elected were R. H. Denham, M.D., of Grand Rapids, Wayne D. Barrett, M.D., of Detroit, and C. S. Gorsline, M.D., of Battle Creek.

The Council elected E. F. Sladek, M.D., Traverse City, as its chairman, and Otto O. Beck, M.D., Birmingham, as vice chairman. R. S. Morrish, M.D., Flint, is chairman of the Publication Committee, C. E. Umphrey, M.D., Detroit, chairman of the Finance Committee, and O. C. Stryker, M.D., Fremont, chairman of the County Societies Committee.

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MICHIGAN'S DEPARTMENT OF HEALTH

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

RAPID TREATMENT CENTER

The Rapid Treatment Center for Venereal Disease of the Michigan Department of Health has been in operation for two month. "Open House" for physicians, health officers, and other persons interested in the Center was held on August 10 shortly after the Center was opened.

For the past few weeks the average hospital census has been fifty or sixty patients. Although the hospital has a capacity of 100 beds, a shortage of nurses and other personnel has required operation at less than capacity. It is hoped that this shortage will soon be remedied. Only infectious cases of venereal diseases are eligible for admission. The usual length of hospitalization is about ten days, although this period may be somewhat shortened for patients with gonorrhea. In any event, two or three days of hospitalization of patients is necessary to carry through pre-treatment and post-treatment clinical and laboratory examinations.

Physicians are urged to make preliminary arrangements with the Medical Officer in charge before sending their patient to the Center. Patients coming to the Center without previous arrangements for admission cannot be admitted. Requests for information can be directed to your local health officer or the Bureau of Venereal Disease Control, Michigan Department of Health.

NEW DIAGNOSTIC SERVICE FOR DENTISTS

It is now well established that a bacterial examination of saliva can be made which will indicate the activity of caries in that mouth and if very active a certain procedure prescribed which if carried out by the patient will greatly reduce the amount of decay.

The physicians of the state have long had free diagnostic service provided by the Michigan Department of Health and now the department is making this diagnostic service available to the dentists of the state.

FLUORINE EXPERIMENT

Painstaking research by the U. S. Public Health Service has definitely shown that in areas where there is one part per million of fluorine naturally in the drinking water, children using that water from birth have 50 per cent to 60 per cent less caries than in areas where there is no fluorine in the water. Also that in this dilution there are no harmful effects from the water.

To determine whether by adding 1 ppm. artificially to the drinking water will produce the same result the city of Grand Rapids has agreed to co-operate with the State Department of Health, the U. S. Public Health Service to carry out such an experiment. Careful check up of children will be made before the introduction and periodically thereafter and the study will probably continue for ten or fifteen years. If it is proved that the same results obtain as when the fluorine is naturally in the drinking water, as seems likely, it will be a marvelous aid in reducing one of the greatest afflictions of our people.

POLLEN SURVEY

The Michigan Department of Health has been conducting a pollen survey with funds granted by the legislature. This survey began in July, 1944, and is conducted by laboratory studies of pollen slides exposed daily in thirty-one stations throughout the lower peninsula. These slides are collected and mailed weekly to the laboratory for counting. Total counts of ragweed pollen are made on these slides and reported to the Commissioner for distribution.

The pollen activities for the Upper Peninsula are being handled this year by the Michigan College of Mining and Technology. Equipment and material were supplied by the Bureau of Laboratories. A full-time botanist on the staff of the college is making the counts for the Upper Peninsula. A pollen station has been established in each of the counties in the Upper Peninsula, and findings found in these stations are reported to Lansing for ultimate compilation. This study will be conducted until frost.

COMMUNICABLE DISEASES

Communicable disease totals for Michigan for the first eight months of 1944 are as follows:

	Jan. 1 to Sept. 1, 1944	7-year median
Diphtheria	189	171
Lobar Pneumonia	1,125	2,005
Scarlet Fever	6,758	8,204
Poliomyelitis	421	82
Whooping Cough	2,891	8,168
Measles	26,494	21,147

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Woman's Auxiliary

With this issue of The Journal of the Michigan State Medical Society the 1943-44 officers and committee chairman of the Woman's Auxiliary to the Michigan State Medical Society transfer to their successors the administration of this splendid organization. All agree they have enjoyed their year of service. Some will continue to act in the same or new capacities, whereas others, after having completed many years of functioning officially, will withdraw from active participation in the work of the Executive Board. The members of the Auxiliary thank these women for the hours of labor they have devoted to this organization and the valuable service they have rendered.



Mrs. John J. Walch

As the Presidents-Elect have more opportunity to visit the counties and become better acquainted with the individual members, they will select as their Committee chairmen fewer Past Presidents. This is a commendable procedure and is indicative of the fast-approaching maturity of the Michigan Auxiliary. Since the experience of the past is of value in determining the policies of the future, it is always desirable to have on the Board a few women who are familiar with the problems and decisions of the past. The counties should be proud to have members from their units elected to state offices or chosen to be committee chairmen. There are necessarily only a limited number of participants in the convention program, but where selections are to be made they are directed to the counties contributing most to the successful completion of the Auxiliary program. The size of the county membership is not the criterion—rather it is the accomplishment in relation to the number of active members.

The officers are very eager to have the President visit personally as many county chapters as possible. Experience has proved this the best connecting link between state and county. The President has an opportunity to observe:

1. Who is working (potential state executive material).
2. What is being done.
   (a) In execution of adopted state program.
   (b) In developing original projects.
3. What remains to be done.
   (a) Causes for neglect of certain portions of state program.
   (b) Necessary personnel changes to be made within county organization.
   (c) What state departments should contribute greater assistance.
4. Problems peculiar to county.
5. Inadequacy of state direction.
   (a) Lack of understanding of the over-all plan of the state.
   (b) Incomplete, indefinite direction.
   (c) Infrequent contact with state officials.

The retiring President highly recommends that the President-Elect accompany the President on as many county visits as possible.

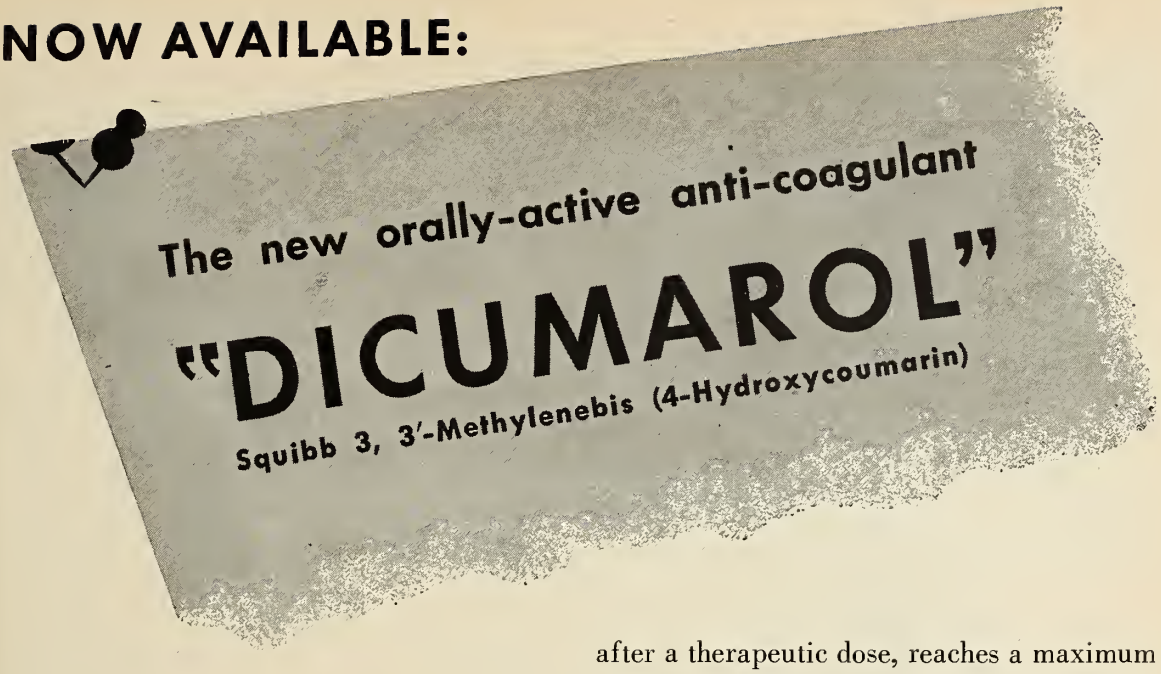
When the President resides in the central portion of the state, she can readily accept the invitations of the county auxiliaries to come to them at the time most desirable to them. The more distant counties will of necessity have to entertain the President when it is most convenient for her to come. The co-operation extended the President this past year has been outstanding and thoroughly appreciated by the officers as well as the President. It is preferable to have the President come at the first opportunity after the State Convention in order that she may present the program to the many members who were not at Convention. Often, however, units prefer to present their President at one of their more gala meetings where they can summarize their accomplishments of the year. Every county should invite the President at some time during the year and send her a memorandum of its meeting dates. When the President calls on a county auxiliary, the county president should have in readiness all the questions she wishes to discuss with the President and should arrange to have her officers and committee chairmen confer with the President on any problems they are meeting in the administration of their duties.

All county chairmen are urged to present any suggestions they may have to the state committee chairman or the President. Only in this way can the state chairmen learn how to be of greatest help to the county members of their committee. It is hoped that each county is developing a very complete list of instructions for each office. The Handbook cannot be sufficiently detailed to competently care for the county work. If each chairman will keep accurate record of (1) calculated demands and supplies, (2) actual arrangements made, (3) final results, the work of the following year can be greatly simplified. For example, a county auxiliary plans a tea. Expecting to serve 100 people the chairman of the party makes plans for a specific number of cakes, et cetera. When 150 guests are finally served, she records what quantities were actually consumed, where supplies were secured, and so on. Accordingly, the chairman the following year will know just how to go about giving such an affair.

This has been a very important year in our history. We have responded to the invitation to service extended us by our government and our parent organization. We

(Continued on Page 914)

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WOMAN'S AUXILIARY

(Continued from Page 912)

know we have helped materially in Michigan's oversubscribing its United States Army Cadet Corps quota and in keeping the Murray-Wagner-Dingell Bill in committee.

Vital, intriguing new problems are in line for 1944-45. Let us attack them with the same spontaneity we brought to our 1943-44 projects. We have made a name for ourselves; we must maintain our reputation.

When Auxiliary members are invited to assume responsible posts in civic groups approved by the Medical Society they should accept willingly, for they are indicating to society the calibre of the Auxiliary membership.

The officers and press chairman, Mrs. Walter Boughner, hope you have made a habit of reading this Auxiliary page in THE JOURNAL and have not been disappointed. Won't you please send suggestions as to what you would like to find here and contributions (original or excerpts).

In bidding adieu, your President extends to her successor, Mrs. H. L. French, thanks for her unlimited co-operation this year and best wishes for a successful and enjoyable term of office. To the entire membership of their Auxiliary she extends thanks for their outstanding accomplishments, for the gracious hospitality and courtesies extended her everywhere and always, and for the honor of serving as the executive of such a remarkable group of women.

MARY NEE WALCH
Immediate Past-President

— Subscribe to The Bulletin —

How many members-at-large have you brought into the Auxiliary this past year? Can't you better your record this coming year? Many doctors' wives would like to belong to the Auxiliary but are too far distant or few in number to form a chapter. These women want to know what the Auxiliary is doing. Much of the propaganda work they can do individually. Check your list of acquaintances today and write a few letters of invitation.

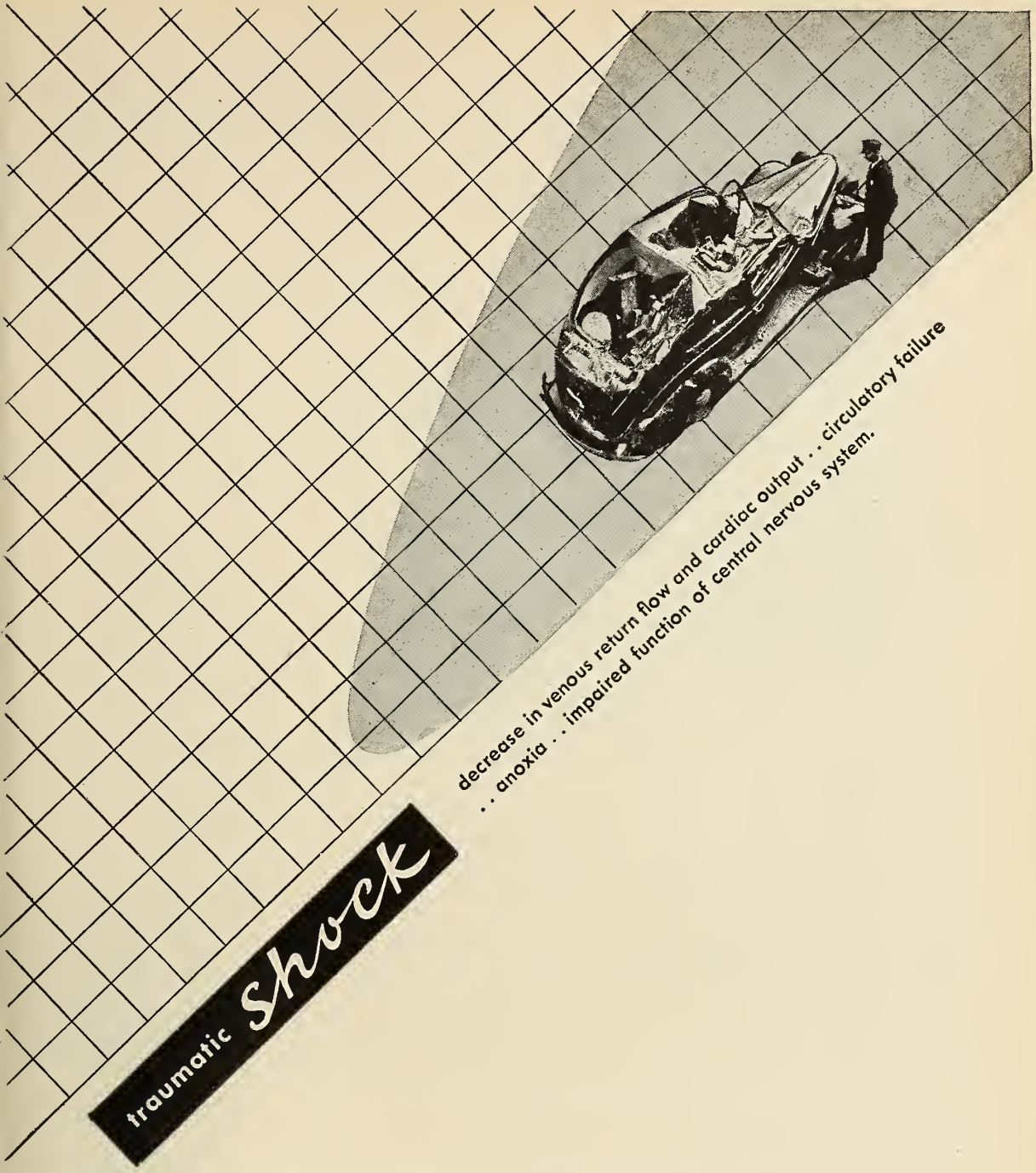
* * *

Have you seen the movie, "Dr. Wassell?" Frightful as the scenes of war are, it portrays the wonderful work the absent members are doing.

* * *

The *Bulletin* contains the report of the national convention. Did you note that Mrs. Wm. J. Butler of Grand Rapids (a Past President of Michigan) is the National Program Chairman for this year? She has just completed four years of service as a Director. Congratulations, Mrs. Butler.

— Subscribe to The Bulletin —



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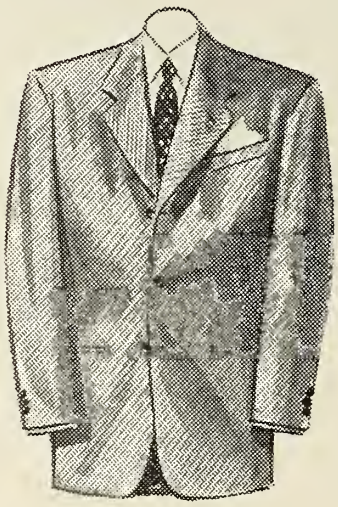
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In Memoriam

DIED IN MILITARY SERVICE

John P. Keefe of Detroit was born March 6, 1916, in Detroit and was graduated from the University of Detroit and from Wayne University College of Medicine, June, 1942. He served his internship at Receiving Hospital. On July 1, 1943, he entered service and had been overseas since April with the 90th Infantry Division. Lieutenant Keefe died on June 26, in France, of injuries received on Invasion Day. His gentle manliness and unassuming manner made friends of all who knew him. Medicine was his life's work and his passing was in fulfillment of his vocation.

G. A. Skully of Detroit was born on July 28, 1911, in Flint and was graduated from the Detroit College of Medicine in 1936. From 1936 to 1937 he interned at Seymour Hospital, Eloise. In the late fall of 1937 he began to practice general medicine. In 1942 he joined the Armed Forces. Two weeks before his death, Captain Skully completed his training as a pilot and received his wings. He studied Eye, Ear, Nose and Throat at Randolph Field and he was in charge of that division at the Syracuse Army Air Base Hospital. Doctor Skully died on July 13, 1944.

A. J. Bower of Greenville was born in 1881 in Greenville and was graduated from the University of Michigan in 1905. He spent two years at Lakeside Hospital, Cleveland, and went to Greenville to practice with his father, the late H. L. Bower, M.D. In 1914 he visited England, returning home after the outbreak of the war and in 1917 became a captain in the Grand Rapids Hospital Unit Q which was stationed at Auteil, France. He returned to Greenville in 1919 where he practiced until the time of his death, August 21, 1944.

Ferdinand Chenik of Detroit was born in 1892 in Austria and was graduated from the University of Michigan in 1924. He received his early education in European schools, including pre-medical work at the University of Leipzig, Germany. He moved to Canada in 1913 and came to Detroit where he founded Chenik Hospital. Through his hospital and membership in philanthropic organizations, he won wide recognition for charitable work. He was a student of international politics and was an active member of several French and Polish societies and other national groups. He was the author of two books and many articles on tuberculosis. Doctor Chenik died August 16, 1944, in Westlaco, Texas.

(Continued on Page 918)

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IN MEMORIAM

(Continued from Page 916)

A. W. George of Detroit was born in 1883 in Baltimore and was graduated from the Baltimore Medical College in 1911. He joined the staff of Providence Hospital as Resident Surgeon and after April 23, 1914, became associated with the Packard Motor Car Company as Chief Surgeon, which position he held actively until last May when his physical condition forced him to enter Harper Hospital. He was a Charter Member and Fellow of the American Association of Industrial Physicians and Surgeons. Doctor George died on July 21, 1944.

A. V. Murtha of Pontiac was born April 23, 1890, at Shepard and was graduated from the University of Michigan Medical School in 1914. His first medical work was with the Cleveland Clipper Mining Company hospital in the Upper Peninsula where he spent two years. In 1916 he entered the private practice of medicine in Flint. The following year he entered the Army Medical Corps. He was stationed in Washington and at Ford Hospital. After his separation from the Army in 1919, Dr. Murtha went to Pontiac where he engaged actively in the practice of medicine and surgery until his death. He served as medical director of Wilson Foundry & Machine Company since 1921. He was a member and past-president of the medical staff of Pontiac General Hospital. Doctor Murtha died August 18, 1944.

ON THE RUN

Polycystic kidneys, hypertension, and renal tuberculosis are often complicated by pyelonephritis.

•

Benign adenomas of the lung occur more often in the large bronchi than in the small.

•

Recent experimental data indicates that shock victims, particularly those suffering from crushing, do better when kept in a cool atmosphere.

•

Approximately eighty per cent of cases of male renal tuberculosis present tuberculous lesions of the genitalia.

•

In adrenal insufficiency the heart size remains small.

•

The more silent and less inflammatory the thrombosis in the lower limbs, the greater the likelihood of pulmonary embolism.

•

In Hodgkin's disease, it is advisable to choose for biopsy a lymph node from the neck or axilla, provided there is one of sufficient size readily accessible.

•

Amicrobic pyuria and cystitis often yield to removal of foci of infection and to two or three intravenous injections of 0.2 to 0.3 grams neoarsphenamine given at intervals of five days.

•

The Queckenstedt test should never be performed during a diagnostic lumbar puncture on a patient with a craniocerebral injury.

•

Pain from spasm of the small intestine is usually referred above the umbilicus, while that originating in the large bowel is apt to be referred below this point.

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✶ COUNTY AND PERSONAL ACTIVITIES ✶

Lt. Col. Harrison S. Collisi, MC, formerly of Grand Rapids, has been made Commanding Officer of the 197th General Hospital at Camp Ellis, Ill.

* * *

Butterworth Hospital, Grand Rapids, sponsored a scientific exhibit on "Hip Fractures" and "Factors Influencing Wound Healing" at the 1944 MSMS Annual Session.

* * *

$29,562,742.54 has been contributed by the American people in the last eleven years to conquer infantile paralysis, according to a statement of the National Foundation of Infantile Paralysis.

* * *

Russell N. DeJong, M.D., Ann Arbor, is the author of an original article "Mechyl Bromide Poisoning, with Special Reference to Nervous System Manifestations" which appeared in JAMA of July 8.

* * *

The hard-working and efficient Press Relations Committee at the MSMS Annual Session in Grand Rapids was composed of Torrance Reed, M.D., W. B. Mitchell, M.D., R. S. VanBree, M.D., and Andrew Van Solkema, all of Grand Rapids.

The Cover

Surgeons beginning the work which saves the life of a private in the South Pacific are pictured on the cover of this number of THE JOURNAL. This photo was obtained through the courtesy of the Bureau of Public Relations, War Department, Washington, D. C.

* * *

Frederick A. Coller, M.D., Clarence E. Crook, M.D., and Vivian Iob, Ph.D., Ann Arbor, are the authors of an original article entitled "Blood Loss in Surgical Operations" in JAMA of September 2.

* * *

John W. Hirshfeld, M.D., Matthew A. Pilling, M.D., Charles W. Buggs, Ph.D. and William E. Abbott, M.D., of Detroit are authors of an original article "Penicillin and Skin Grafting" which appeared in JAMA of August 12.

* * *

C. R. Keyport, M.D., Grayling, immediate Past-President of the Michigan State Medical Society, addressed the Grand Rapids Rotary Club on September 28, during the MSMS Annual Session. His subject was "Medical Practice, and Security."

(Continued on Page 922)

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COUNTY AND PERSONAL ACTIVITIES

(Continued from Page 920)

The Michigan State Board of Registration in Medicine advises the suspension of the licenses of Clifford Shepard Pine, M.D., of Newtown, Conn., of Edward Harry Thomas, Jr., M.D., Detroit, and of Mark Edward Harmeyer, M.D., of Adrian for violation of the Michigan Medical Practice Act.

* * *

A new course in Industrial Hygiene and Sanitation began at Wayne University this fall, according to Dean William W. Whitehouse of the College of Liberal Arts. It deals with environmental factors in industry affecting the health of the worker and with measures of control.

* * *

Fred R. Reed, M.D., Three Rivers, chairman of the Public Relations Committee of the Michigan State Medical Society, addressed a joint meeting of the St. Joseph County Medical-Dental and Pharmaceutical Society and their Auxiliary at the Klinger Lake Country Club on August 8. His subject was "Federal Bureaucracy and Regimentation."

* * *

A Recent Census Bureau study reveals that for the first time in the history of the nation, the 1944 elections will find more women than men of voting age, although the absence of men in armed forces has not been the deciding factor. An analysis of potential voters discloses that eight million more persons are now of voting age than there were in 1940; of the 88,600,000 potential voters, 44,600,000 are women.

* * *

A Postgraduate Assembly on Nervous and Mental Diseases, and War, sponsored by the Institute of Medicine of Chicago will be held on November 1-2, 1944, in the Palmer House, Chicago, and will be devoted to phases of neurology, psychiatry, and neurosurgery that are of particular importance at this time to clinicians and specialists in the fields mentioned. Interested physicians are invited to attend. Registration fee of $5.00. For details write the Institute at 86 E. Randolph, Chicago 1.

* * *

Office assistants and other office employes of members of the Michigan State Medical Society were given their first opportunity to obtain the surgical protection offered through Michigan Medical Service, during September.

R. L. Novy, M.D., MMS president, said that enrollment in the surgical plan was opened to doctors' office employes as the result of numerous requests. Many of the office employes already were enrolled in the hospital plan offered through Michigan Hospital Service and the opportunity to enroll for hospital care was reopened for those not previously protected simultaneously with the surgical enrollment.

(Continued on Page 924)

IN THE ARTHRITIDES

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COUNTY AND PERSONAL ACTIVITIES

(Continued from Page 922)

R. H. Denham, M.D., Grand Rapids, served as Ubiquitous Host to Captain Arthur W. Frisch, MC, and R. Earle Smith, M.D., of Grand Rapids served as Ubiquitous Host to S. Wm. Becker, M.D., on the occasion of the MSMS Annual Session in Grand Rapids. Fred P. Currier, M.D., Grand Rapids, served as Ubiquitous Host to F. A. Brockenshire, M.D., and Arch Walls, M.D., of Detroit served as Ubiquitous Host to M. C. Smith, of Nebraska. Thanks are expressed to these hosts for their hospitality to our guest essaysists.

* * *

Checking Bureaucrats.—The new policy of the British Government to maintain a constant check for Parliament on various governmental decrees and use of powers granted to agencies of the Empire, was a severe setback to those critics of Congress who are irked because Congress is at last seeking to regain some of the power it delegated to the Bureaus. The London Daily Mail says: "Yielding gracefully to the demand of all parties, the British Government announced in the House of Commons the acceptance of a check on delegated legislation—a curb that may to some extent prevent bureaucratic-made laws going beyond the limits parliament intended. It has for years been one of the prime anxieties of M.P.'s that powers which have been willingly given to Ministers in order to win the war might be prolonged into the peace and form a very irksome domination over individual rights."

The Congress in its revision of OPA law is fully aware of New Deal tendencies and the necessity for our checking Bureaucratic ambitions in this country. The OPA law will succeed only with the co-operation of the people.

—Fred L. Crawford, MC, 8th District, Michigan.

* * *

SAVE THE BEST IN ALL

It is but natural that American doctors should oppose Federal socialization of medicine. They have seen such systems curb incentive and progress in the medical field in other nations, and remove the personal relationship between doctor and patient, leaving in its stead an official system as impersonal as medical examinations at Army induction centers. If that's what this nation wants, socialized medicine will fill the bill. But the people should remember that it is not the doctors, but Mr. and Mrs. John Jones who will be the losers.

In seeking a practical method for voluntary pre-payment of medical costs to meet prolonged or serious illnesses, the public should not be misled by alluring promises of "free medicine" at the hands of the state. There can, however, be the fullest co-operation between Federal and local governments, industry, the people and the medical profession, to extend voluntary methods of health insurance without the regimentation and compulsion that inevitably follows socialized medicine.

Government can help solve such problems as malnutrition, bad housing, and inadequacy of Federal, state and municipal health programs. One of the legitimate functions of government is to seek ways and means to correct social and economic conditions which cause disease, and which all the health insurance in the world will not remedy.

Therefore, let us retain the great advantages of private

(Continued on Page 926)



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COUNTY AND PERSONAL ACTIVITIES

(Continued from Page 924)

medicine but add to them the benefits that will accrue from the co-operation of government and industry in eliminating causes of illness, as well as providing easy and economical methods of paying for it.—Editorial by Fred D. Keister, Jr., *Ionia* (Mich.) *County News,* August 17, 1944.

* * *

MAKING AN HONEST DOLLAR

"The fiscal medicine men of Washington have developed two prescriptions for curing our economic ills which may do the patient more harm than good while he sleeps peacefully under their narcotic effect," according to Harley L. Lutz, Professor of Public Finance, Princeton University.

"Prescription No. 1 is the legend of the mature economy, which reasons that the government must support the people because the people no longer can support themselves. This attained peak popularity during the depression as a means of rationalizing the then growing trend toward deficit financing. We were told that the last frontier had been crossed, there were no green fields for future expansion, technology had soared to its zenith and further industrial progress was virtually impossible. The boys who have had a look at the broad undeveloped lands of North Africa, Australia, China, Indo-China, and who have watched the progress of radar, electronics, plastics, air transport—just to mention a few—may now find this palliative for deficit spending a bitter dose to swallow.

"Prescription No. 2 combines the sweet-scented government guarantee of high wages and security for all with the carefully camouflaged bludgeon of destructive taxation. It is just becoming apparent to the patient that in order to enjoy the pleasant sedative effect of the former he must suffer more and more blows from the latter. The thousands thrown out of work by the 30 per cent cabaret tax are the most recent group to see the light and they don't seem to like it.

"Free Enterprise Suffers.—Gradually the entire enterprise system is becoming groggy from being constantly drugged and beaten. These quack prescriptions are not to aid the patient but combine obviously to justify more government spending and to increase government pay rolls. The doctor is performing an operation for a fat fee when all that may be needed is a simple diet.

"Instead of all the talking and planning that is now heard about saving or restoring and stimulating the enterprise system after the war, a short and simple formula is offered here as being all that is necessary. This formula, addressed to every citizen, is as follows:

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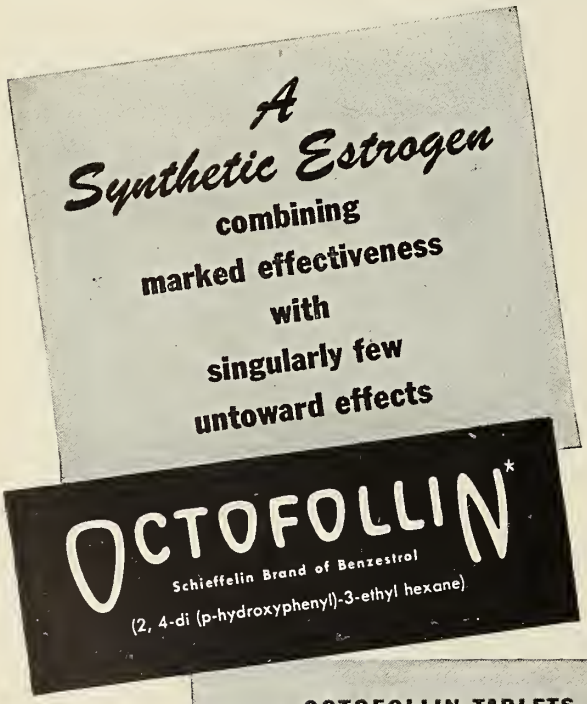
THE DENTAL TREATMENT MAXILLO-FACIAL INJURIES WITH SUPPLEMENTARY MATERIAL ON CASES AND TECHNIQUES. By W. Kelsey Fray, M.C., M.R.C.S., L.R.C.P., L.D.S. (Eng.), Consulting Dental Surgeon to the Royal Air Force, Consulting Dental Surgeon to the Ministry of Health, Dental Surgeon to Guy's Hospital; P. Rae Shepherd, L.D.S., R.C.S. (Eng.) Dental Surgeon, East Grinstead Maxillo-facial Unit; Alan C. McLeod, D.D.S. (Penn.), B.Sc. (Dent.), Toronto, L.D.S., R.C.S. (Eng.), Dental Surgeon, East Grinstead Maxillo-facial Unit; and Gilbert J. Parfitt, M.R.C.S., L.R.C.P., L.D.S., R.C.S. (Eng.), Dental Surgeon, East Grinstead Maxillo-facial Unit; Unit. With Foreword by Professor F. R Fraser, M.D., F.R.C.P., Director General, Emergency Medical Service; and a Section on Fractures of the Middle Third of the Face by A. H. McIndoe, M.S., F.R.C.S., F.A.C.S., Consulting Plastic Surgeon to the Royal Air Force, Surgeon-in-Charge, East Grinstead Maxillo-facial Unit. Philadelphia and Montreal: J. B. Lippincott Co., 1944. Price $6.50.

The last war brought great progress in the treatment of Maxillo-facial injuries, and this war has intensified that study, by bringing together many cases and many skilled surgeons, thus furnishing an ideal opportunity for advancement of exact knowledge as well as an opportunity to compare results. This book takes much of its subject-matter from the clinics, lectures and demonstrations of H. M. Forces at East Grinstead Maxillo-facial Center. It is published in response to numerous calls for notes upon these courses. It is especially prepared for dental surgeons. It is profusely illustrated, giving pictures of injuries, methods of approach, instruments and appliances used and the results. The treatment of injuries is detailed, even giving the days after the injury when certain procedures are to be carried out. This American edition is a valuable addition to our array of texts on essential subjects, selected from the vast field of surgery.

HYDRONEPHROSIS AND PYELITIS OF PREGNANCY. By H. E. Robertson, M.D., Section on Pathologic Anatomy, Mayo Clinic, Rochester, Minnesota. 332 pages with 11 illustrations. Philadelphia and London: W. B. Saunders Company, 1944. Price $4.50.

Dr. Robertson has approached his subject of pyelonephritis of pregnancy from the historical standpoint. He says he thought the gathering of this information would not be too involved but it ran into real research work. He gives the early contributions on disturbances of the urinary tract in pregnancy, and the anatomic relations of the ureters. This is followed by a historical survey of writings on eclampsia, ureteral compression and dilatation. A larger chapter covers the historical approach to pyelitis, ureteral compression and dilatation, and infection. Several other chapters cover historical consideration of the influence of the nervous system, urography, potassium-calcium ratios and end-results of hydronephrosis and pyelitis in pregnancy. A review of the textbooks is followed by the author's discussions and con-

(Continued on page 930)



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(Continued from Page 928)

clusions. There are references given to 974 articles, listed seriatum as they occur in the text. It would have been much more valuable to have listed them alphabetically. Now they are useful only as reference reading in reference to this book, for you cannot turn to any individual reference without double checking through the index, and reference list. The book is a most valuable contribution to the knowledge of this subject, by classifying and making it available.

MINOR SURGERY. Edited by Humphrey Rolleston and Alan Moncrieff. New York: The Philosophical Library, 1944. Price $45.00.

This is a collection of twenty-three chapters written by outstanding English surgeons, each giving in concise and clearly described form the treatment and management of the minor surgical procedures of his field of practice. Minor wounds, sprains, the feet, the hand, the mouth, the nose and throat, the ear, the eye, bursæ and ganglia, are a few of the subjects, and the treatment in the text is conservative, with the advice to send the patient to a specialist if too complicated or requiring extra skill.

PSYCHIATRY AND THE WAR. By Frank J. Sladen, M.D., Physician in Chief, Henry Ford Hospital, Detroit; Trustee, McGregor Fund. A survey of the Significance of Psychiatry and its Relation to Disturbances in Human Behavior to help provide for the Present War Effort and for Postwar Needs. Springfield, Ill., and Baltimore, Md.: Charles C. Thomas, Publisher. Price $5.00.

This war has brought psychiatry to the front as has no other experience. The examinations of recruits, the study of problem cases, the readjustment of misfits, or persons who have not measured up to the requirements of tasks and responsibilities rarely given in the past has called upon men trained in psychiatry. The MacGregor Fund called a conference at the University of Michigan and this volume is a presentation of the proceedings of that conference. Thirty papers and two symposia are presented, and the material is invaluable to the present and future efforts in caring for the disturbances of human behavior.

THE PRINCIPLES AND PRACTICE OF OPHTHALMIC SURGERY. By Edmund B. Spaeth, M. D., Professor of Ophthalmology in the Graduate School of Medicine of the University of Pennsylvania, Philadelphia; Attending Surgeon Wills Hospital; Consultant in Ophthalmology, Philadelphia Hospital for the Insane (Byberry); Assistant Ophthalmologist to the Rush Hospital, Philadelphia; Fellow, The American College of Surgeons, Philadelphia College of Physicians; Fellow, The American Academy of Ophthalmology and Otolaryngology. Third Edition, thoroughly revised. Illustrated with 556 engravings, containing 798 figures and 6 colored plates. Philadelphia: Lea & Febiger, 1944. Price $11.00.

Doctor Spaeth in this third edition of his text has made a thorough revision of the subject matter and has added much new material. It is profusely illustrated and makes a complete and conservative guide to ophthalmic surgery, which has been approached largely from a medical standpoint. The book is small for its

Say you saw it in the Journal of the Michigan State Medical Society

934 pages, in conformity to the war requirement of paper conservation. That makes it more easily handled, for such a large and complete text. The teaching is conservative, and complete.

COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION. Edited by Richard M. Hewitt, B.A., M.A., M.D.; A. B. Nevling, M.D.; John R. Miner, B.A., Sc.D.; James R. Eckman, A.B.; and M. Katherine Smith, B.A. Volume XXXV—1943. 875 pages with 208 illustrations. Philadelphia and London: W. B. Saunders Company, 1944. Price $11.00.

The volume of collected papers of the Mayo Foundation for 1943 takes its place along with the many preceding as authoritative reports outlining and cataloging the progress of medicine during that year.

NEW AND NONOFFICIAL REMEDIES. 1944, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1944. Cloth. Price, postpaid, $1.50. Pp. 778. Chicago: American Medical Association, 1944.

The current volume of New and Nonofficial Remedies reflects two important and forward looking decisions of the Council, namely, to use the metric system exclusively in all its publications, and to consider for acceptance contraceptive preparations offered for use as prescribed by physicians. These decisions in turn reflect the vigorous and progressive leadership of the Council in the service of Medicine.

Some of the new preparations that appear in this volume are: Succinylsulfathiazole, a new sulfonamide, a proprietary brand being "Sulfasuxidine"; Diodrast Concentrated Solution, a preparation of the already accepted Diodrast, for use in a special diagnostic procedure for visualization of the circulatory system and also cholangiography; a preparation of Sodium Benzoate for use as a liver function test; Mersalyl and Theophylline, accepted under the name Salyrgan-Theophylline Tablets, proposed as an adjunct to intravenous injection of the already accepted drug; Zinc Insulin Crystals and Zine Insulin Injection Crystalline; Tetanus Toxoid; and Concentrated Oleovitamin A and D, a dosage of the pharmacopœial preparation.

MEDICAL DIAGNOSIS. By Roscoe L. Pullen, A.B., M.D., Instructor in Medicine, Tulane University of Louisiana School of Medicine; Assistant Clinical Director, Charity Hospital of Louisiana at New Orleans; formerly Fellow in Clinical Endocrinology, Duke University School of Medicine and Duke Hospital, Durham, North Carolina. With a Foreword by John H. Musser, B.S., M.D., F.A.C.P., Professor of Medicine, Tulane University of Louisiana School of Medicine; Senior Visiting Physician, Charity Hospital of Louisiana at New Orleans. 1106 pages with 584 illustrations and 12 colored plates. Philadelphia and London: W. B. Saunders Company, 1944. Price $10.00.

Dr. Pullen has succeeded in producing a volume on diagnosis that considers the patient, and searches for the reason of his discomfort or inability to do the things he wishes to do. The reason the patient consults the doctor is sought and an attempt made to relieve the disability. This text studies the patient as a sick person, and not just some one with a particular disease. There are twenty-seven contributors, each presenting the methods and means of making a diagnosis of the diseases

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QUICK REFERENCE BOOK FOR MEDICINE AND SURGERY. A Clinical, Diagnostic, and Therapeutic Digest of General Medicine, Surgery, and the Specialties, Compiled Systematically from Modern Literature by George E. Rehberger, A.B., M.D. Twelfth Edition, Philadelphia-London-Montreal: J. B. Lippincott Company, 1944. Price $15.00.

This is a reference encyclopedia for the use of the practitioner in looking up any subject in which he is interested. It is divided into eleven parts, and in each part the diseases are treated alphabetically. There is a diagnostic description or definition frequently with pictures. This is followed by an enumeration of the causes, prognosis, and treatment. This twelfth edition, appearing after a four-year interval contains much entirely new material. The information is sufficiently complete to act as a reliable guide in diagnosis and treatment.

CATARACT AND ANOMALIES OF THE LENS. Growth, Structure, Composition, Metabolism, and Treatment of the Crystaline Lens. By John G. Bellows, M.D., Ph.D., Assistant Professor of Ophthalmology, Northwestern University Medical School. With 208 Illustrations and 4 color plates. St. Louis: The C. V. Mosby Company, 1944. Price $12.00.

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REBEL WITHOUT A CAUSE. The Hypnoanalysis of a criminal Psychopath, By Robert M. Lindner, Ph.D., United States Public Health Service (R). Psychologist United States Penitentiary, Lewisburg, Pa., Lecturer in Criminology, Bucknell University. Introduction by Sheldon Glueck, LL.B., Ph.D., Professor of Criminal Law, and Criminology, Law School, Harvard University, and Eleanor T. Glueck, Ed.D., Research Criminologist, Law School, Harvard University. New York: Grune and Stratton, 1944. Price $4.00.

This book is a study of the psychopathology of the born criminal. Psychopathology is a disorder of behavior which affects the relationship of an individual to his social order. The author is using hypnosis as an aid to research and treatment. He discusses the plan, and practice, claiming that hypnosis can be obtained if sufficient effort is made, and sufficient time given. A habitual minor criminal came to the attention of the author and he has given us a complete study, made from a microphone record. The patient underwent forty-six hours of interviews and hypnoanalysis, and the



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material is presented as a guide to methods and a report on results. This book should be very valuable for such psychopathological studies. It is an interesting diversion for any well-informed student of intricate medical problems.

RADIATION AND CLIMATIC THERAPY OF CHRONIC PULMONARY DISEASES. With Special Reference to Natural and Artificial Heliotherapy X-Ray Therapy, and Climatic Therapy of Chronic Pulmonary Diseases and all forms of Tuberculosis. By Edgar Mayer, M.D., F.A.C.P., F.A.C.C.P., Assistant Professor of Clinical Medicine, Cornell University Medical College, New York City; Attending Physician New York and Memorial Hospitals; Special Pulmonary Consultant, New York State Dept. of Labor; Formerly Member Faculty Trudeau School for Tuberculosis; Director (ex urbe) Northwoods and Will Rogers Tuberculosis Sanatoria, Saranac Lake, New York; Consultant on Tuberculosis to the Government of Cuba; Board Member of the Finlay Institute of the Americas. With the Collaboration af the Following Contributors: Louis B. Baldwin, Irvin I. Balensweig, Alfred L. Briskman, William Chang, Anthony C. Cipollaro, William W. Coblentz, Lloyd F. Craver, Martin Dworkin, Earl C. Elkins, John N. Hayes, Ira I. Kaplan, H. H. Kasabach, Eugene Kisch, Frank H. Krusen, Henry Laurens, Maurice Lenz, Horace LoGrasso, Harriet C. McIntosh, Clarence A. Mills, Leroy S. Peters, Homer L. Sampson, Stanley L. Wang. Baltimore, Md. The Williams & Wilkins Company, 1944. Price $5.00.

This is a complete symposium on the treatment of all forms of tuberculosis by all sorts of light and climatic benefits. The contributors are well known and their teaching accepted. The book is intended for the general practitioner and the chest specialist, and presents much of the author's experience and those of his collaborators.

FERTILITY IN MEN. By Robert Sherman Hotchkiss, B.S., M.D., Lieut. Commander, MC, USNR, Assistant Professor of Urology, New York University Medical College; Instructor in Surgery (Urology) Cornell Medical College; Assistant Visiting Attending, Department of Urology, Bellevue Hospital, etc. With a Foreword by Nicholson J. Eastman M.D., Chairman, Educational Committee, National Committee on Maternal Health. 95 Illustrations. Philadelphia: J. B Lippincott Company, 1944. Price $3.50.

FERTILITY IN WOMEN. By Samuel L. Siegler, M.D. F.A.C.S., Attending Obstetrician and Gynecologist, Brooklyn Women's Hospital; Assistant Obstetrician and Gynecologis and Attending Sterility Clinic, Greenpoint Hospital; With a Foreword by Robert Latou Dickinson, M.D., 194 Illustrations. Philadelphia: J. B. Lippincott Company, 1944. Price $4.50.

The treatment for sterility has become a major problem in many practices, and these two companion books furnish authoritative and practical directing in approaching the problem. The books were produced to be supplemental to each other. The problem involves both husband and wife in most instances, and here is assembled outlines of approach, the physical and personal examinations necessary, the causes of sterility in both sexes, and the methods of diagnosis and treatmen The obstetrician who is most apt to be consulted i these problems should have at his disposal the be technique, the latest knowledge of the subject, and a sy



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ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1943. Cloth. Price, postpaid, $1.00. Pp. 150. Chicago: American Medical Association, 1944.

The present volume of reprints contains only eight reports on rejected articles; it is interesting to note that objections to these are on a much higher plane than those it was necessary to urge against the flagrantly quackish preparations of earlier days.

Perhaps the most noteworthy of the nineteen general and "status" reports in this volume is the one declaring the Council's intention of using henceforth only the metric or centimeter-gram-second system in its publications. The report itself gives some interesting and readable history on the subject of weights and measures. Of most timely interest to the general physician as well as the endocrine specialist is the report on nomenclature of endocrine preparations. The report gives a currently quite complete list of the available commercial preparations, including those not accepted by the Council as well as those which stand accepted. Another report in the field of endocrinology is that recognizing the use of estrogens in the treatment of prostatic carcinoma.

ORTHOPEDIC NURSING. By Robert V. Funsten, M.D., Professor of Orthopedic Surgery, University of Virginia Medical School, and University of Virginia Hospital School of Nursing; and Carmelita Calderwood, R.N., A.B., Consultant in Orthopedic Nursing, National League of Nursing Education, 181 Text Illustrations. St. Louis: The C. V. Mosby Company, price $3.75.

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Cheplin Biological Laboratories, Inc. 861, 877
Ciba Pharmaceutical Products, Inc. 915
Insert, facing page 856
Classified Advertising 935
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Colwell Publishing Co. 935
Commercial Solvents Corporation 846, 847
Cook County Graduate School of Medicine 933
Crane Discount Corporation 935
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Henry A. Luce, M.D., Detroit.....194
T. K. Gruber, M.D., Eloise.....194
C. R. Keyport, M.D., Grayling.....194

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H. H. Cummings, M.D., Ann Arbor194
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MEDICAL AID TO VETS

Honorably Dicharged Men to Enjoy Lifetime Benefits under GI Ballot Rights and Present V. A. Laws

By James Marlow

Washington—Army and Navy Hospitals take care of the ill, injured or wounded serviceman.

Then, at the finish of all the treatment that can be given him, one of three things happens:

1. He is able to go back on active duty.

2. He is found unfit for active duty, is discharged for disability, can ask for a pension, and is sent back into civilian life.

3. He is found not only unfit for active duty but in need of prolonged or permanent hospital treatment. In that case he is discharged from the military service, can ask for a pension, and is transferred to a veterans' hospital nearest his home.

These veterans' hospitals are operated by the Veterans Administration (VA).

In group No. 3 could be cases like these: tuberculosis, mental derangement, blindness, heart disease, severe asthma, and badly crippled men.

But what of veterans who, because of some disability connected with their military service, need hospital treatment anytime after their discharge from the service?

Any honorably discharged veteran, who has a disability connected with his military service, can get free treatment anytime after his discharge at any VA hospital.

It's all free to him: Transportation to the hospital, bed, operations, medicine, nursing, food, as long as he needs hospitalization.

Suppose the same class of veteran—honorably discharged—doesn't need to stay in a hospital but does need medical service or dental care for a condition caused or aggravated by his military service.

That would be called out-patient treatment. He could get that free, too, and it includes medicine, appliances, bridgework, and so on. He also gets this from VA.

What about the veteran who has no service-connected disability, such as one who has been out of the service for years and is suddenly stricken with appendicitis. Can he get free hospitalization?

Yes, if he was not dishonorably discharged and if he says he can't pay for the hospitalization. If he can't pay for transportation to the hospital, he gets that free, too. (If he says he can pay for the hospitalization, he doesn't get it at all.)

If beds are scarce—they haven't been so far—the veteran with the service-connected disability gets first claim over the veteran with the nonservice-connected disability.

The pension of a veteran who has a service-connected disability is cut to $20 monthly if he is hospitalized for a certain length of time and has no dependents; if he has dependents his pension is not cut at all, no matter how long he is hospitalized.

The pension of a veteran who has a nonservice-connected disability is cut to $8 a month after he has been hospitalized a certain length of time.

(A veteran, discharged in good health from military service, can get a pension if anytime afterward he is totally or permanently disabled by any cause not due to his own misconduct. For example: He might have been hit by a train, losing his legs and eyesight.)

The VA operates 94 hospitals, with more than 88,000 beds. It expects to have more hospitals and at least 108,000 beds in two years. The hospitals are in all states except Delaware, Rhode Island and New Hampshire. The VA says hospitals will be opened in those states.

Furthermore, the VA expects the peak claim on VA beds to be reached in 1975 when the VA plans to have 300,000 beds.

TESTIMONIAL TO MICHIGAN MEDICAL MEN IN MILITARY SERVICE

The 1944 House of Delegates of the Michigan State Medical Society, at its Grand Rapids Session, September 25-26, stood in silent tribute to those Michigan Doctors of Medicine who have died on the field of battle in the present war.

A reiteration of the testimonial to all Michigan military men (2,174), as adopted by the 1943 House of Delegates, was recommended by The Council, and unanimously adopted by the House with a rising vote:

"While here assembled in annual session, it seems fitting and proper that we give recognition to the services rendered by hundreds of our members who are serving in the armed forces in defense of our country, often in surroundings and under conditions too terrible to imagine. Therefore, shall we express to our absent members, through our State Journal, our sincere hope and wish for their success and their safe return, at the conclusion of a successful conflict; and, further, that this House of Delegates do honor to those of our members who have made the supreme sacrifice on the field of battle, by standing for a moment with bowed heads in their memory."

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Biolac provides for *all* nutritional needs of young infants, except vitamin C. This completeness assures you that the baby will get all the nutritional elements required—in amounts necessary for optimal growth and health.





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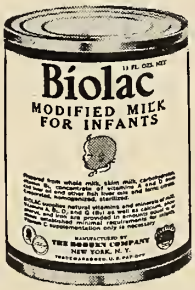
It's easy to prepare.

Less chance of upsets due to errors in preparing formulas. Less chance of formula contamination. Biolac requires only dilution with boiled water, as you prescribe. No extra ingredients to calculate.

For standard formulas, simply dilute 1 fl. oz. of new concentrated Biolac with 1½ fl. ozs. water. Feed 2½ fl. ozs. of this formula daily for each pound of body weight.

Biolac is readily available at all pharmacies, in the new 13 fl. oz. can. Therefore, no interruption of feeding schedules.

**Biolac is prepared from whole milk, skim milk, lactose, vitamin B, concentrate of vitamins A and D from cod liver oil, and ferric citrate. Evaporated, homogenized, sterilized. Vitamin C supplementation only is necessary. For detailed information, write Borden's Prescription Products, 350 Madison Avenue, New York 17, N.Y.*



NO LACK IN

BIOLAC

Borden's complete infant formula*

STATE MEDICINE

PROPOSED CONSTITUTIONAL AMENDMENT

■ A COMPLETE state-operated compulsory social insurance system for Michigan is in process of initiation. A proposed amendment to the State Constitution has been prepared which, if adopted, would weave such a scheme into our fundamental law much along the lines of that proposed for the Federal Government in the Wagner-Murray-Dingell Bill.

An initiative petition to submit the amendment to the voters has been presented to the Secretary of State and approved as to form. This is the usual procedure prior to circulating petitions and obtaining the voters' signatures necessary to place it on a ballot for adoption or rejection.

The amendment would add a new section to Article VI of the Constitution to be known as Section 23. It is quite a lengthy document. It contains 45 paragraphs and no attempt will be made in this paper to give a complete digest of it. I shall endeavor only to point out to the profession its highlights and some of its manifestations.

A social insurance fund is to be created through the collection of one and one-half per cent of all remuneration paid by employers of one or more persons. Employment includes all types of service with the exception of Federal Government service, service performed by ordained or licensed ministers and that performed by regular members of religious orders in the exercise of their religious duties.

Contributions to this social insurance fund are also required from all persons of an amount equal to one per cent on the first $5,000.00 of net income as defined by the "income tax statute of the United States"; two per cent on the next $15,000.00; and three per cent on all above $20,000.00 Employers are to be held responsible for the collection of these income tax contributions from their employes.

The persons required to make the income tax contributions include every individual, corporation, partnership and association excepting political subdivisions of the state, the United States Government and nonprofit corporations exempt from Federal income taxes.

The writer has not attempted to collect the data necessary to estimate what these yearly contributions would total but certainly the sponsor or sponsors of the amendment expect it will be hundreds of millions of dollars.

Now, what is to be done with these vast sums of monies? One of the principal uses is to furnish complete medical, surgical, dental, pharmaceutical, hospital and nursing services to "all persons who have their normal place of residence in the state," for themselves and for any children of whom they have for the time being the care and control.

The department set up to administer the plan is to have the sole discretion to determine whether a person has a "normal residence" in the state. This department is to be called the Michigan Social Insurance Commission. It consists of one commissioner appointed by the Governor for a six-year term. There are eleven divisions set up within the commission but the main authority and responsibility is placed with one man, the commissioner.

The medical benefits are to be furnished in such manner as "to provide for the prevention of diseases and for the application of all necessary diagnostic and curative procedures and treatment and periodic physical examination."

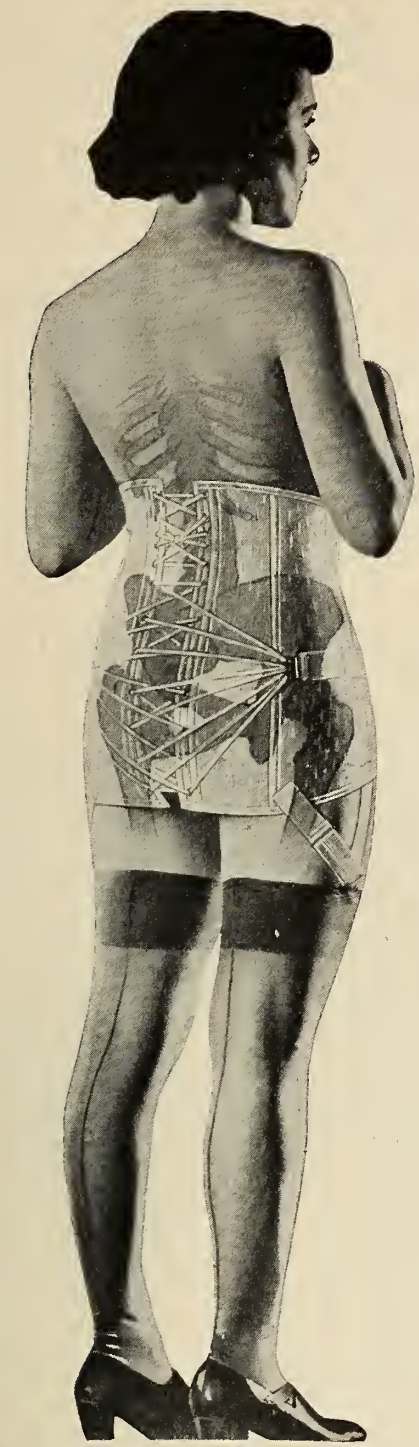
The Social Insurance Commission is given authority to make such arrangements as it deems advisable with licensed physicians, dentists, and with nonprofit voluntary hospitals, municipal hospitals, county hospitals, state hospitals, and university hospitals in order to be able to furnish the medical, dental and hospital benefits contemplated by the amendment; it also may make similar arrangements with any person, firm or organization it desires for the furnishing of pharmaceutical supplies and nursing services.

Disability benefits, the minimum amount of which are fixed by the amendment, must also be paid out of this social insurance fund. After payment of administration expenses, disability benefits and cost of health benefits and proper reserves are set up, grants in aid are to be paid out of the social insurance fund to various government authorities of all kinds to be expended in government works and to provide reserves for public works projects which are enumerated in great detail and which run almost the entire gamut of human endeavor.

The amendment creates within the Social Insurance Department complex administrative machinery with five boards, commissions or councils, five subdepartments with a director at the head of each, and an indefinite number of referees. The Commission also has wide authority in hiring employes and fixing their compensation. The present Department of the State known as Workman's Compensation, now under the jurisdiction of the Labor Department, and the Unemployment Compensation Department are both to be transferred to the Social Insurance Commission and there administered. Notwithshtanding these various boards and councils, the chief authority, as previously stated, is centered in the Commissioner who would have more power in the employment of individuals and the spending of money than any other state official not excepting the Governor. In addition, the medical, dental, hospital, pharmaceutical and nursing professions will be shackled to government machinery having the full power of dic-

(Continued on Page 946)

Analyzed for THE JOURNAL by W. J. Griffin, LL.B., Detroit, President of Michigan Hospital Service.



Patient of thin type of build — skeleton indrawn

ANATOMICAL SUPPORT
for faulty
BODY MECHANICS

In conditions of faulty body mechanics, the nonuse of the abdominal muscles allows the pelvis to rotate downward and forward, bringing the sacrum up and back. There results an increased forward lumbar curve with the articular facets of the lumbar spine crowded together in the back. The dorsal spine curves backward with compression of the dorsal intervertebral discs and the cervical spine curves forward with the articular facets in this region closer together. Therefore, chronic strain of the muscles, ligaments and joints of the spine and pelvis occurs.

Camp Anatomical Supports have an adjustment by means of which their lower sections can be evenly and accurately brought about the major portion of the bony pelvis. When the pelvis is thus steadied, the patient can contract the abdominal muscles with ease and then with slight movement straighten the upper back.

Relieving back strain and fatigue, due to faulty body mechanics is a feature of the Camp Support illustrated, and other types for Prenatal, Postnatal, Postoperative, Pendulous Abdomen, Visceroptosis, Nephroptosis, Hernia and Orthopedic conditions.

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STATE MEDICINE

(Continued from Page 944)

tation. No attempt has been made through the amendment to protect the present relationship between the physicians and dentists and their patients, nor the right of the individual to select his own physician, dentist, hospital or nurse.

It should also be of concern to all of us that this amendment goes much farther than the Murray-Wagner-Dingell Bill in the regimentation of the profession. That Bill does not pretend to give complete medical and hospital service because noncontributors to the fund receive no benefits under it and there are restrictions as to time and the amounts to be paid. In this Michigan amendment "all persons who have their normal place of residence in the state" are to have complete medical service whether or not they have ever contributed a dime to the Social Insurance Fund and the Social Insurance Commission is given full discretion to decide whether an applicant has such residence in the state to become eligible for it. From such decision no appeal can be successfully taken. Can there be much question that we have here in this amendment too much power to give to one man or any group of men no matter what their ability, their character and integrity? If it had been in operation under the state administration during the depression years of 1933 and following, the doctors, dentists, and hospitals of Michigan would have been obliged to turn away thousands of seekers of medical care because of sheer physical inability to take care of them and because thousands of applicants would have obtained a "normal place of residence in the state" solely for that purpose.

I have said and believe the administrative power created by this amendment cannot in the long run be safely placed in any person or group of persons. I am satisfied the author of this amendment believes that the plan for health care which it embodies must so center such dangerous authority for it to have any chance at all of functioning because without such power the red tape necessary would bungle its operations.

Isn't it well for all of us to ask ourselves why legislation of this type can obtain substantial sponsorship? Why, for instance, men like Professor Altmeyer, chairman of the Federal Social Security Board, persistently champion it? Is it because the public generally either has already lost or is definitely losing confidence in the members of the medical profession or, for that matter in the dental, nursing and hospital profession as well? This has been decisively answered in the negative by the results of the recent survey taken in Michigan by the Michigan Hospital Council and by other surveys made under the auspices of the medical profession in California and other sections of the country. The profession has well earned that confidence and this reassurance is very heartening to all who believe in the American system of doing things.

Now there are different types of individuals advocating state operation of all health programs and for different reasons. However, they are all relying for their support upon another factual situation disclosed by the surveys, namely, a quite general demand for a method of distributing health care so as to relieve present financial burdens. The cost of furnishing medical and hospital care has been rapidly increasing during the past decade and the indications are that such cost will continue to increase rather than to decrease. The complaint is not that the doctors and hospitals are charging too much but that for the middle and low-income groups some method must be devised to distribute that cost so as not to be too burdensome to pay. The philosophy of the advocates of government operation is that, while those people are willing to pay on a basis they can afford to pay, they will not do so unless the government takes the money from their earnings and for that reason the government only can satisfactorily furnish health service. The surveys show the public has not yet accepted that philosophy but, on the contrary, the people will pay on a voluntary basis and that they have confidence the medical profession can operate a plan which will enable them to do so. It is to be hoped that confidence is never lost by the profession.

NON-MEDICAL AID PLANS PREFERRED

Michigan State Medical Society Is Told Findings of Survey

Results of a survey indicating that a majority of people in Michigan prefer medical-hospital insurance plans sponsored by the medical profession to those administered by the government were given to members of the Michigan State Medical Society here last night.

Dr. R. L. Novy, president of the Michigan Medical Service, declared in presenting the survey that it was Michigan's answer to the Murray-Wagner-Dingell bill now pending in congress and that it would provide a basis for future developments in health insurance.

Of some 5,000 persons interviewed, the survey showed that 33 per cent voted for voluntary plans sponsored by the medical profession, 15.5 per cent for tax-supported government programs, and 26.6 preferred simply to pay for medical services when illness arises.

Five years ago the Michigan Medical Society sponsored two organizations for medical-hospital insurance as its alternative to government-sponsored plans. Although 650,000 persons now are enrolled in the plans, 75 per cent of all those questioned did not know such plans existed, Dr. Novy said:

"You have gone out and thrown mud on the government plan," he told the doctors. "Yet you have done little to advance or advertise your own."

Urging them to work actively toward increasing their own program, he advised his audience to "throw away socialized medicine prejudices and look at the facts."

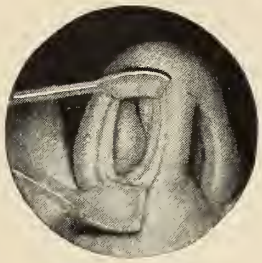
"A desire for collective health security has been developed by the people," he asserted. "When given no choice they will have the security and under government control, but when given a choice they want your plan.

The survey also was designed to determine what Michigan patients think of their doctors. It showed 9 per cent thought the doctors were doing a good job and 28 per cent said they did not think doctors were as honest as they should be with patients. Other complaints included overcharging, six per cent; keeping patients waiting, four per cent, and lack of interest in patients, almost two per cent.—*Battle Creek Enquirer News,* September 29, 1944.

A better means of nasal medication

BEFORE TREATMENT

Inferior and middle turbinates are highly engorged and in contact with the septum. The airway is completely blocked.



9 MINUTES AFTER TREATMENT

Maximum shrinkage has been obtained with 2 inhalations from Benzedrine Inhaler. The turbinates are contracted. The airway is open.



Butler and Ivy state that—for administering vasoconstrictive drugs—inhalers and sprays are preferable to nasal drops, and are—in most cases—"the better means of nasal medication," because: (1) ". . . the drug reaches the nasal mucosa in more diffuse form . . ."; (2) " . . . the mucosa is never severely ischemic at any one point, but the effect is spread throughout the nasal cavity . . ."; (3) even when prolonged medication is required, there is ". . . far less pathologic change than that resulting from the use of nasal drops."

Arch. Otolaryng., 39:109-123, 1944.

Each Benzedrine Inhaler is packed with racemic amphetamine, S. K. F., 200 mg.; oil of lavender, 60 mg.; and menthol, 10 mg.

Smith, Kline & French Laboratories, Philadelphia, Pa.

Benzedrine Inhaler

Rapid, Complete and Prolonged Shrinkage

GENERAL PRACTICE

THE GENERAL PRACTITIONER VIEWPOINT

Within the Michigan State Medical Society, there is now a Section on General Practice recently promulgated by the Society to place the general practitioner in a group as important in itself as any other section of specialized groups. Within this section, the general men can now demonstrate if they are capable and willing to fight for their opinions as the various problems and issues arise involving them.

"The General Practitioner Viewpoint" is a new idea of the Section on General Practice and will be continued in the JOURNAL from time to time so long (and just so long) as there proves to be interest in it. The idea is intentionally constructive and will be edited with great care to be fair and logical in all viewpoints. Interest in its perpetuation can be demonstrated by the general practitioners in submitting their opinions and suggestions for publication and discussion in this column. Certainly, we are faced with enough important debatable problems today involving our group to make an interesting section in each issue of the JOURNAL. By this method the strong opinions and arguments of the few may be made known to all—and there is a need for it too because there are those who are anxious to know our feelings.

We are oftentimes too prone to keep our grievances under the proverbial basket too long and then criticize ultimate decisions made by the few (and decisions must be made, you know); when those decisions may have been more satisfactory to all of us had we not hidden our grievances. Yes, the time and opportunity has now come and is before us in general practice to open up and say what we think of the EMIC Program, the Wagner-Murray-Dingell Bill, the MMS, our overburdensome war practice on the home front, et cetera. Your approvals as well as disapprovals will be appreciated as help in construction of future editions of this column.

Within the past few years, there has developed a feeling on the part of the general practitioners of medicine that many problems and issues facing the profession as a whole are being considered and adjusted without too much consideration of the true opinions of the general practitioner. This is indeed due solely to the lack of organization and forceful opinion of the men in general practice. Our members are in the vast majority with a definite present minority of influence and the correction rests entirely and squarely on our shoulders. There is certain strength in a sound organization—so the avenue is wide open in our Section on General Practice to avail ourselves of the proffered opportunity. Shall we remain a sleeping giant?

This column also invites news items of general interest to its readers. We shall be glad to know what GP shot the largest deer or caught the largest fish. All items will assist in creating an interesting sustaining article.

LUTHER W. DAY, M.D.,
Secretary, Section on General Practice, Michigan State Medical Society

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SULPHONAMIDE ALLERGY

Forty cases of both internal and eczematous allergy were investigated by skin tests and oral medication with various sulfonamides, sulfanilic acid, and procaine. Reactions in the eczematous cases consisted of a local flare-up plus a general dermatitis, starting in about six hours, and, in the internal cases, of pyrexia starting in about two hours. The skin test used in the eczematous cases was a modified scratch technique with 50 per cent pastes of powdered sulfonamides in hydrous lanolin and a two per cent lanolin paste of procaine. The final method evolved was that of applying to one long scratch four different test materials on pieces of cloth about an inch apart, covering for forty-eight hours. The positive reaction was seen on that part of the scratch in contact with the irritating substance only. For oral testing the various sulfonamide drugs were used, giving an initial dose of 0.5 gm. and if no reaction appeared, increasing to 1 gm. every four hours for forty-eight hours.

The results showed twenty-four (60 per cent) persons to be allergic to one sulfonamide drug only; sixteen (40 per cent) reacted to multiple sulfonamides and to sulfanilic acid.—R. G. PARK, Brit. M. J., London, No. 4353 781-783, June 10, 1944.

The striking success of Paredrine-Sulfathiazole Suspension in nasal and sinus infections is largely due to its prolonged bacteriostatic action. When the Suspension is administered on retiring, for example, sulfathiazole can often be observed on infected mucosa the next morning—conclusive evidence that bacteriostasis has persisted all night long.

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ECHOES OF 1944 WAR CONFERENCE

A total of 1,449 persons registered at the 1944 Postgraduate Conference on War Medicine, the 79th Annual Session of the Michigan State Medical Society, held at the Pantlind Hotel-Civic Auditorium, Grand Rapids, September 27-28-29:

Doctors of Medicine	921
Guests	276
Scientific and Technical Exhibitors	252
GRAND TOTAL	1,449

* * *

What some of the guest speakers and others wrote about the 1944 War Conference (unsolicited):

F. H. Falls, M.D., Chicago: "May I compliment you on the efficiency with which the meetings were conducted, and the facilities provided for the speakers. I enjoyed very much being with you and wish to say that my hosts more than did their duty, and it was a real pleasure to have an opportunity to see them again."

* * *

John W. Harris, M.D., Madison: "I should like to take this opportunity to tell you that my day spent with your Society was a most pleasant one in every particular. I saw many old friends, and all of the members with whom I came in contact were most pleasant and agreeable. I should like to extend my appreciation to you and also to express my admiration for the organization and conduct of your meeting."

* * *

Arthur W. Proetz, M.D., St. Louis: "Permit me to thank you for the courtesies shown me at your recent meeting and for the expeditious management of all the details."

* * *

Joseph L. Baer, M.D., Chicago: "I want to take this opportunity to express my admiration for the careful attention to detail which was manifest throughout my stay, and to thank the Michigan State Medical Society for the bowl of fruit which was delivered to my room at the Pantlind, and which I enjoyed."

* * *

E. A. Rovenstine, M.D., New York: "I want you to know that my recent visit and participation in the Annual Session of the Michigan State Medical Society is a pleasant memory to me. I appreciate the many courtesies and kind hospitality that was mine during the time I was in Grand Rapids. Doctor Willis L. Dixon, my immediate host, was most efficient.

"Kindest thanks."

* * *

M. M. Zinninger, M.D., Cincinnati, Ohio: "I had a most enjoyable trip attending the Michigan State Medical Society's meeting at Grand Rapids last week. I was very well cared for by the members of the profession who lived in Grand Rapids and I had the pleasure of renewing a number of old acquaintances."



PAST PRESIDENT'S SCROLL

Council Chairman V. M. Moore, M.D., Grand Rapids, presents the Past President's Scroll to Claude R. Keyport, M.D., Grayling, at Officers' Night ceremonies, Grand Rapids, September 27, at MSMS 79th Annual Session.

The Scroll presented to Past President Keyport contained the following acknowledgment:

"This token is presented by the Michigan State Medical Society to Claude R. Keyport, M.D., President, 1943-44, in deep appreciation and grateful recognition of distinguished service rendered to medicine."

The Scroll was signed by V. M. Moore, M.D., as Chairman of The Council, and by L. Fernald Foster, M.D., as Secretary.

G. deTakats, M.D., Chicago: "I wish to thank you for the hospitality and many courtesies extended to me during my stay in Grand Rapids."

* * *

Robert A. Moore, M.D., St. Louis: "I enjoyed the visit in Grand Rapids and the opportunity to meet the physicians and pathologists of Michigan."

* * *

James L. Wilson, M.D., New York: "I enjoyed my stay in Grand Rapids very much."

* * *

Sidney Farber, M.D., Boston: "I had a splendid time at Michigan. I wish to take this opportunity to thank

(Continued on Page 954)



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Councilors W. H. Huron, M.D., Iron Mountain and E. R. Witwer, M.D., Detroit, and Treasurer Wm. A. Hyland, M.D., Grand Rapids, were not present when the photograph was taken in Grand Rapids on September 25, 1944.

---

you and your colleagues for your hospitality and for your courtesy."

* * *

Edward H. Reinhard, M.D., St. Louis: "I want to thank you very much for a most enjoyable time while at the convention. I don't remember ever having been to a convention I enjoyed any more thoroughly."

* * *

"The Michigan Pathological Society desires to express its sincere appreciation to the Michigan State Medical Society for the courtesy and co-operation extended to it in the preparation of the program of the section on Radiology, Pathology and Anesthesia. The meetings were enthusiastically received by all who attended."

* * *

A. R. Yaukulis of H. J. Heinz Co., Pittsburgh: "This was the first Michigan State Medical Society convention in which I participated. My fellow exhibitors built me up to expect great things at this convention; they were right. The accommodations, the labor, the co-operation and the entertainment were 100 per cent perfect. It was a pleasure to work with the Michigan State Medical Society members, and I feel that we have made some excellent contacts through this convention."

* * *

S. M. White of C. B. Fleet Co., Lynchburg, Va.: "We have received a report from our representative on the recent convention in Grand Rapids. Mr. Reed is loud in his praise of the way you co-operated with the exhibitors and he says that you requested not only in the program, but also directly to the profession to be sure to visit the exhibits and register.

"It is always a pleasure to patronize your Society at these conventions on account of just this kind of co-operation our representative refers to. We appreciate it, and shall anticipate with pleasure again renewing our contact with you at your next meeting."

* * *

ACKNOWLEDGMENTS

A. C. Furstenberg, M.D., Ann Arbor, led the Discussion Conference on Otolaryngology on Wednesday, September 27, in place of H. Lee Simpson, M.D., Detroit, who was unable to reach Grand Rapids.

* * *

Arthur C. Curtis, M.D., Ann Arbor, was leader of the Discussion Conference in Dermatology on Wednesday, September 27. Dr. Curtis took over the leadership of this conference in place of Colonel Udo J. Wile, M.C., who was absent from the state due to official military duty.

* * *

Hazen Price, M.D., Detroit, acted as leader of the Discussion Conference in Medicine, on Wednesday, September 27, on the occasion of the 1944 MSMS Annual Session. The guest conferee was Edward H. Reinhard M. D., Department of Internal Medicine, Washington University School of Medicine, St. Louis, Mo., who spoke in the period originally assigned to Tom D. Spies

(Continued on Page 1027)

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Two postgraduate credits have been given by the Michigan State Medical Society to all its members who registered and attended the 1944 Postgraduate Conferenct on War Medicine held in Grand Rapids, September 27-28-29.

The total registration of Doctors of Medicine at the 79th Annual Session of the Michigan State Medical Society was 921.

Those regrstering on Monday, Tuesday and Wednesday, September 25-26-27, included:

Monday and Tuesday

R. V. Allen, Grand Rapids; T. G. Amos, Detroit; F. T. Andrews, Bay City; H. J. Andries, Detroit; Robert J. Armstrong, Kalamazoo; Emilie Arnold-Clarke, Detroit; Ronald M. Athay, Detroit.

W. W. Babcock, Detroit; Louis J. Bailey, Detroit; Abel J. Baker, Grand Rapids; Robert H. Baker, Pontiac; Wyman D. Barrett, Detroit; W. E. Barstow, St. Louis; D. C. Beaver, Detroit; O. O. Beck, Birmingham; Myron G. Becker, Edmore; Wm. L. Bird, Greenville; Frank M. Boet, Grand Rapids; Leon M. Bogart, Flint; Walter H. Boughner, Algonac; Robert S. Breakey, Lansing; Donald R. Brasie, Flint; J. D. Brook, Grand Rapids; James S. Brotherhood, Grand Rapids; A. S. Brunk, Detroit; C. F. Brunk, Detroit; Frederick G. Buesser, Detroit; Volney Butler, Detroit; Mary Lou Byrd, Grand Rapids.

Alexander M. Campbell, Grand Rapids; Duncan Campbell, Detroit; Mary B. Campbell, Detroit; Clarence L. Candler, Detroit; E. I. Carr, Lansing; A. E. Catherwood, Detroit; L. G. Christian, Lansing; Corwin S. Clarke, Jackson; Harry L. Clark, Detroit; James F. Cole, Detroit; Richard C. Connelly, Detroit; Henry Cook, Flint; A. J. Cortopassi, Saginaw; C. V. Costello, Holland; George J. Curry, Flint.

Ernest N. D'Alcorn, Muskegon; Esther H. Dale, Detroit; Milton A. Darling, Detroit; Luther W. Day, Jonesville; Carleton Dean, Lansing; T. E. DeGurse, Marine City; Russell N. DeJong, Ann Arbor; William DeKleine, Lansing; R. H. Denham, Grand Rapids; J. S. Detar, Milan; C. F. DeVries, Lansing; Harry Dibble, Detroit; Willis L. Dixon, Grand Rapids; Frank Doran, Grand Rapids; Fred Drummon, Kawkawlin; Don H. Duffie, Central Lake; Ray M. Duffy, Pickney; Harold D. Dykhuizen, Muskegon.

Nicholas J. Ellis, Croswell; Paul H. Engle, Olivet.

B. J. Fieldhouse, Ida; O. O. Fisher, Detroit; L. Fernald Foster, Bay City; Edson H. Fuller, Grand Rapids.

Harold H. Gay, Midland; Louis W. Gerstner, Kalamazoo; William S. Gonne, Detroit; S. E. Gould, Eloise; T. K. Gruber, Eloise.

A. T. Hafford, Albion; D. B. Hagerman, Grand Rapids; Henry A. Hanelin, Detroit; Ralph E. D. Hawley, St. Claire Shores; W. B. Harm, Detroit; Robert K. Hart, Croswell; L. C. Harvie, Saginaw; Clyde K. Halsey, Detroit; Wilfrid Haughey, Battle Creek; C. L. Hess, Bay City; B. G. Holtom, Battle Creek; Wm. H. Honor, Wyandotte; R. J. Hubbell, Kalamazoo; Leroy W. Hull, Detroit; W. G. Hutchinson, Pontiac.

Stanley W. Insley, Detroit; L. E. Irvine, Iron River.

Robert C. Jamieson, Detroit; Alpheus F. Jennings, Detroit; Ralph A. Johnson, Detroit.

Joseph A. Kasper, Detroit; C. R. Keyport, Grayling; Paul B. Kilmer, Reed City; Earl G. Krieg, Detroit.

Alfred LaBine, Houghton; John H. Law, Detroit; P. L. Ledwidge, Detroit; John L. Lincoln, Lansing; Martha Longstreet, Saginaw; Robert T. Lossman, Traverse City; S. L. Loupee, Dowagiac; C. A. E. Lund, Middleville; Henry A. Luce, Detroit.

Frances L. MacCraken, Detroit; Alexander M. Martin, Grand Rapids; Elta Mason, Flint; Robert McGregor, Saginaw; John P. Marsh, Grand Rapids; S. C. Mason, Menominee; W. C. Medill, Plainwell; A. H. Miller, Gladstone; M. P. Miller, Trenton; W. B. Mitchell, Grand Rapids; H. R. Moore, Newaygo; B. T. Montgomery, Sault Ste Marie; V. M. Moore, Grand Rapids; Louis V. Morand, Detroit; Esli T. Morden, Adrian; Harold Morris, Detroit; Ray S. Morrish, Flint; Dean W. Myers, Ann Arbor; G. L. McClellan, Detroit; T. A. McDonald, Monroe; Wm. B. McWilliams, Maple Rapids.

Albert Noordewier, Grand Rapids; R. H. Novy, Detroit.

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C. E. Umphrey, Detroit; P. R. Urmston, Bay City.

Harvard J. VanBelois, Grand Rapids; V. H. Vandeventer, Ishpeming; V. L. VanDuzen, Grand Rapids.

R. L. Wade, Coldwater; John J. Walch, Escanaba; Roger Walker, Detroit; Arch Walls, Detroit; George Waters, Port Huron; E. H. Webster, Sault Ste Marie; Frank A. Weiser, Detroit; A. V. Wenger, Grand Rapids; Claude L. Weston, Owosso; G. H. Wood, Onaway.

Wm. Rae Young, Lawton.

Wednesday

Uriah M. Adams, Marcellus; Kent A. Alcorn, Bay City; Marshall O. Alexander, Grand Rapids; E. B. Andersen, Iron Mountain; H. B. Anderson, Watervliet; A. L. Arnold, Owosso; John Joseph Angel, Wayne; Mercedes A. Angel, Wayne.

W. O. Badgley, Lansing; Milner S. Ballard, Grand Rapids; Charles W. Balser, Detroit; R. H. Baribeau, Battle Creek; Helen S. Barnard, Muskegon; John B. Barnwell, Ann Arbor; F. Herbert Bartlett, Muskegon; F. W. Baske, Flint; C. M. Baskerville, Mt. Pleasant; Paul H. Bassow, Ann Arbor; E. W. Bauer, Hazel Park; Willard G. Beattie, Ferndale; Sidney A. Beckwith, Stockbridge; R. J. Beeby, West Branch; E. H. Beernink, Grand Haven; C. W. Beers, Muskegon Heights; E. G. Bellinger, Lansing; George W. Bennett, Elsie; Lawrence Berman, Detroit; Major Wm. L. Bettison, Grand Rapids; A. H. Benson, Mancelona, H. M. Blackburn, Grand Rapids; D. C. Bloemendaal, Zeeland; W. B. Bloemendal, Grand Haven; Victor V. Blakeman, Muskegon Heights; E. W. Blanchard, Deckerville; Paul W. Bloxsom, Grand Rapids; H. C. Bodmer, Kalamazoo; Robert E. Bogue, Detroit; Geo. L. Bond, Grand Rapids; Leon C. Bosch, Grand Rapids; Philip A. Boyer, Jr., Ann Arbor; William M. Brace, Ann Arbor; Lewis E. Bracey, Sheridan; Chas. W. Brayman, Cedar Springs; G. M. Brown, Bay City; I. W. Brown, Kalamazoo; Eugene S. Browning, Grand Rapids; Jacob Bruggema, Evart; E. T. Brunson, Granges; S. J. Buist, Grand Rapids; Frank L. Bull, Sparta; Earl L. Burbridge, Detroit; L. J. Burch, Mt. Pleasant; J. G. Burdick, Fennville; D. H. Burley, Almont; W. M. Burling, Grand Rapids; Paul C. Burnett, Grand Rapids; Dean C. Burns, Petoskey; David C. Burnham, Detroit; F. M. Burroughs, Grand Rapids; Earl P. Bunce, Trufant; Frank J. Busch, Saginaw; Earle J. Byers, Grand Rapids.

C. A. Carpenter, Onaway; Edward S. Carr, Sault Ste Marie; M. S. Chambers, Flint; Donald Chandler, Grand Rapids; William S. Chapin, Muskegon Heights; John H. Charters, Flint; Arthur N. Chatel, Detroit; W. P. Chester, Detroit; Daniel M. Clarke, Hastings; Robert W. Claytor, Grand Rapids; M. William Clift, Flint; Carl Amos Coates, Dearborn; John H. Cobane, Detroit; S. G. Cohan, Muskegon; Frederick A. Coller, Ann Arbor; R. C. Conybeare, Benton Harbor; Ralph G. Cook, Kalamazoo; H. E. Cope, Lansing; Burton R. Corbus, Grand Rapids; C. C. Corkill, White Pigeon; E. H. Corley, Jackson; Goldie B. Corn-

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Table of Contents

What the People of Michigan Think of Medicine.
John F. Hunt..... 981

Primary Atypical Pneumonia.
A. A. Applebaum, M.D., and *C. E. Hufford, M.D.*.. 989

What a Modern Army Health Service Should Be.
Brigadier Jonathan C. Meakins, M.D...... 997

President's Page:
Andrew P. Biddle Endows Postgraduate Medicine.1003

Editorial:
What the Public Thinks of Us.....1004
Replies to Criticism.....1005
The Seventy-ninth Annual Session.....1005

Michigan Health Council.....1006

Michigan Physicians' Committee Organized.....1010

County Secretaries Conference in Grand Rapids...1012

Woman's Auxiliary.....1014

County and Personal Activities.....1016

The Doctor's Library.....1022

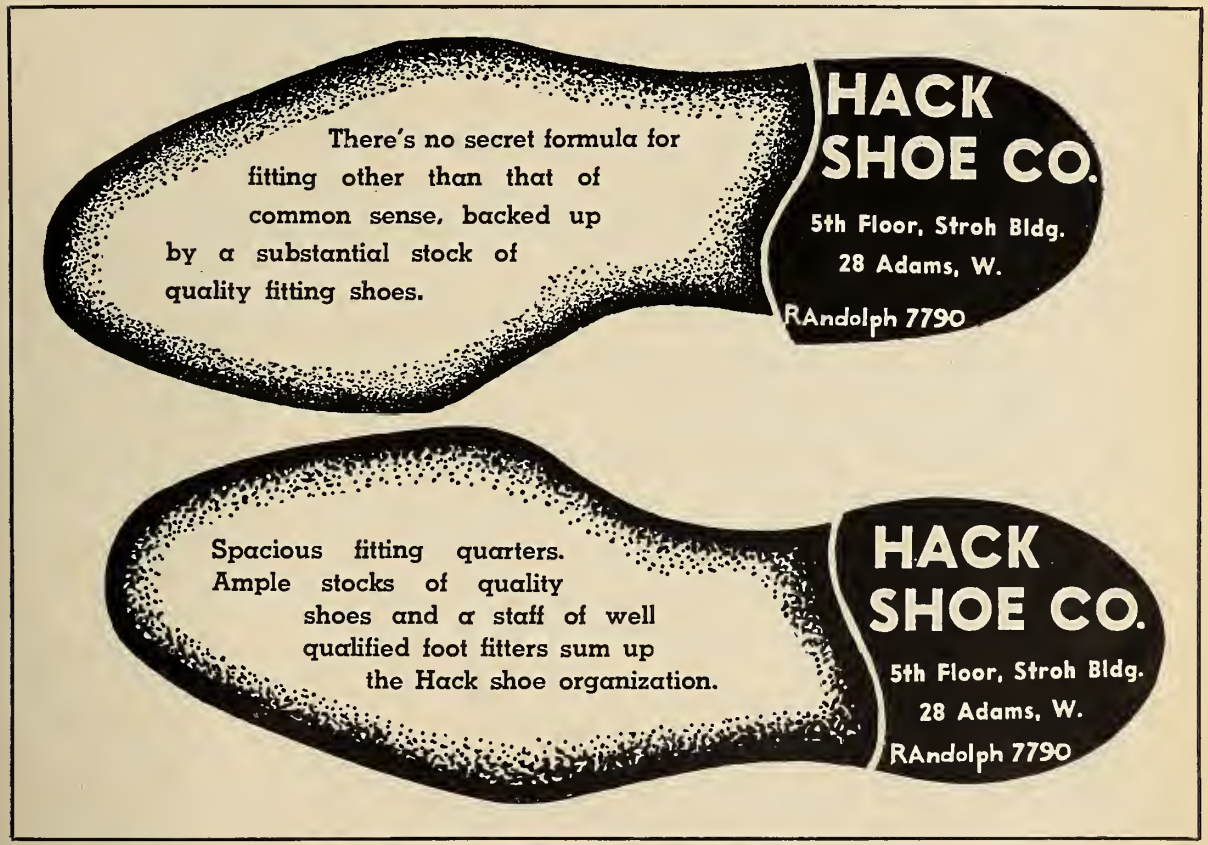
War Medicine:
Medical Aid to Vets..... 942

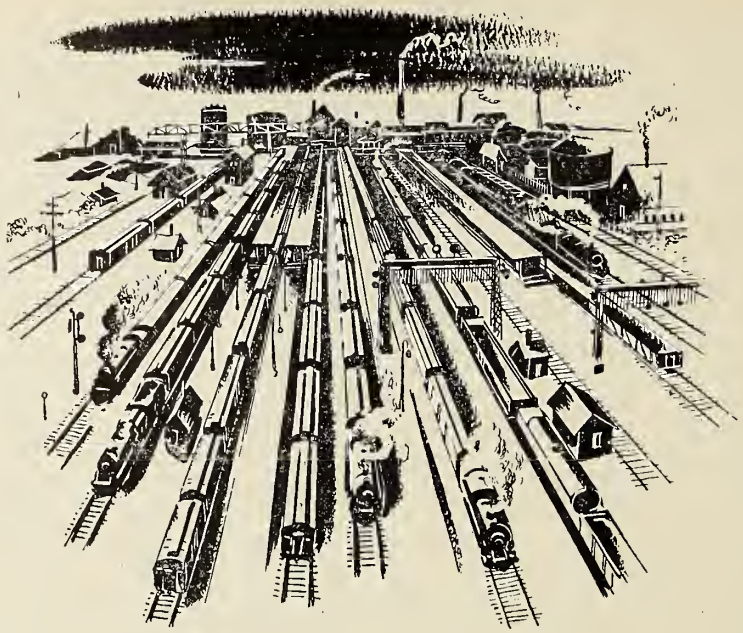
State Medicine:
Proposed Constitutional Amendment..... 944

General Practice:
The General Practitioner Viewpoint..... 948

Echoes of 1944 War Conference..... 952

Credit Is Due..... 956





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The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

Volume 43 November, 1944 Number 11

What the People of Michigan Think of Medicine

By John F. Hunt
Chicago, Illinois



Dr. Novy has just told you that you, in the person of the Michigan Health Council, have caused an examination to be made of the collective mind of Michigan on the subject of medicine. He has told you that tonight we are going to give you the results of that survey—that we are going to tell you "What the People of Michigan Think of Medicine."

That we are going to do, but first I would like to make a few preliminary remarks.

I would like to tell you that we are not in the business of making surveys because we *love* making surveys. We would stop making surveys tomorrow if they were not vital to our real business which bluntly is making the 130,000,000 people of this country think the way our clients want them to think.

An address presented at the 79th annual assembly of the Michigan State Medical Society, Grand Rapids, Michigan, Thursday, September 28, 1944. Mr. Hunt is an executive of Foote, Cone & Belding.

We know, and we know unfailingly, that we can't do that successfully unless we first find out what is already in the minds of these 130,000,000 people. We have to *know* with certainty not only what these people are thinking but what their real interests are—what they want—what they don't want.

The combined annual advertising expenditure of our clients exceeds $30,000,000. With this large expenditure at stake—with the profits of the important businesses it represents, at stake—firms like American Tobacco, Armour, Lockheed, New York Central, Frigidaire, and a score of others equally prominent in their fields, we can't afford to base our recommendations on guess or gamble. We need *Facts*. We can no more write a sound business prescription without facts than *you* can write a sound medical prescription without complete knowledge of your patient's condition.

What do *you* do to arrive at *your* diagnosis?

You put a stethoscope on him—you may use a fluoroscope—you may decide you need some x-rays—you try for a knee reflex—you do a host of things, but the principal basis of your diagnosis in the average case is the answers you get to the questions you ask. *You ask questions.*

That's what we do, too. We know that the only way to accurately diagnose the thinking of 130,000,000 people or the 5,000,000 people of Michigan, is to go to the people *and ask questions.*

Obviously, it's impossible to interview 5,000,000 people. Nor is it necessary, for just as you in medical research find a pattern forming in the treatment of a given number of cases—so do we in our kind of research. The principle that the mass opinion can be accurately established by

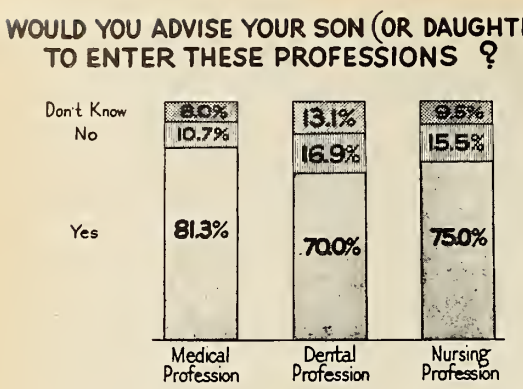


Chart 1

a study of a relatively small number of people properly selected, is completely accepted by all authorities on psychological research.

The accuracy of this kind of research—the sampling method—is being proved commercially by hundreds of cases every year. Perhaps some of you in the medical profession have had no occasion to see or study them. I am sure, however, that all of you are aware of the remarkable record for accuracy that has been turned in, in the last ten years by practically every political poll conducted with a *truly representative cross section* of a state of the nation.

This same sampling method was used to ascertain what "The People of Michigan Think of Medicine."

Across and up and down the state we sent trained investigators to talk personally to a large and properly selected cross section of the whole state of Michigan—more than enough to ascertain accurately what your 5,000,000 citizens think of your profession. These investigators talked personally to approximately 5,000 people representing every class of person able to form an opinion. They spent more than an hour with each of these 5,000 people. They asked twenty-eight basis questions. Out of these twenty-eight questions came 162 cross tables which reveal almost all aspects—certainly the most important aspects—of the opinion of your entire population about medicine and its practice in the state of Michigan.

For the purpose of this presentation and within the limits of the time available, these are the most significant facts:

Chart 1 is self-explanatory. It shows immediately that the people of Michigan are people with opinions. Their opinion on this question is, as perhaps you might expect it to be. Eighty-one per cent would *definitely* advise their son to enter your profession. Those of you particularly who have grown sons know that parents do not lightly consider the question of what career is best for their children. Consequently, you may rightly conclude that the people of this state consider yours as a *fine* profession.

This high estimate of the medical profession is emphasized by the fact that 70 per cent, or 11 per cent less, would advise their sons to enter the dental profession. Even the nursing profession which has always been held in great esteem by the American public did not pull as favorable a vote as a career for the daughters of Michigan.

Among those who had negative opinions of these three professions, there are fewer people who have objections to the medical profession

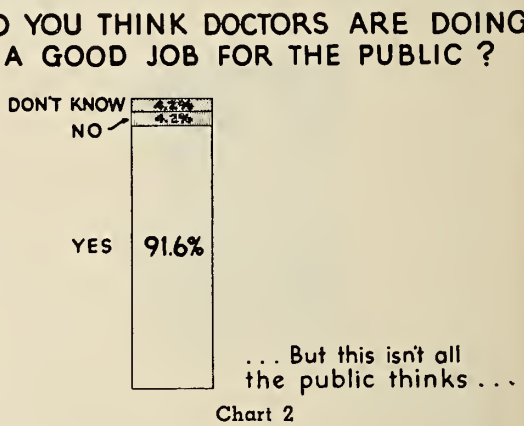


Chart 2

as a career for young people than they had to the two others under question. The principal cause for their negative votes was the fact that it was a hard, difficult life to lead. Particularly after the last couple of years you doctors know what these people had in mind.

The high favor which is evidenced in their responses to this question should be very gratifying to you. However, this next chart will kindle your inner glow ever brighter.

More orchids! And deservedly so. The people of Michigan think you are doing a grand job—and they tell you so in no uncertain terms in their answer to this question (Chart 2). Only 4 per cent have failed to make up their minds. Another 4 per cent of the total have generally decided that you are bad medicine. But 91.6 per cent think you rate a big vote of confidence. Even "The

Indispensable Man" never got a popular vote like that. But this isn't all the public thinks—and remember they *THINK*—and eventually they *ACT*. Here's the first danger signal.

Chart 3 shows that 61 per cent of the people of Michigan think your profession and you doctors in it are honest. 11.2 per cent have no opinion, but despite the fact that as we have just seen on the preceding chart, 92 per cent are willing to give you a Distinguished Service Medal, 28 per cent think you are *not honest*.

You may be interested in the breakdown of that 28 per cent. Here it is: Forty-one per cent of the 28 per cent think you do not give all the facts or tell the truth. Another 18.2 per cent think you overcharge. Fourteen and a half per cent believe you prescribe too many unnecessary treatments.

You may say, "That isn't so bad—not many of

DO YOU BELIEVE DOCTORS ARE AS HONEST AS THEY SHOULD BE IN ALL DEALINGS WITH PATIENTS?

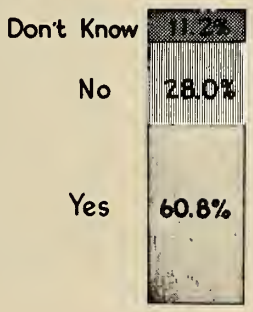


Chart 3

them think we're actually dishonest," but *it is bad*. It doesn't make any difference what their reasons are, the fact remains that 28 per cent of the people of Michigan believe the medical profession is *not as honest as it should be*. You also may say, "They probably think other professions (including the advertising business) are *far less honest*." That doesn't make any difference either. It's *your* business that's being threatened by Senate Bill No. 1161.

Here we begin to really examine the Michigan mind about their attitude on the import of No. S-1161, the Murray-Wagner-Dingle Bill (Chart 4). We find the people of Michigan less inclined to favor government control in medicine than do the people of the nation at large. While this is a bit more encouraging than the national picture, the fact that 39 per cent of the people of

DO YOU THINK WE SHOULD HAVE SOME SORT OF A GOVERNMENT OPERATED MEDICAL-HOSPITAL PLAN?

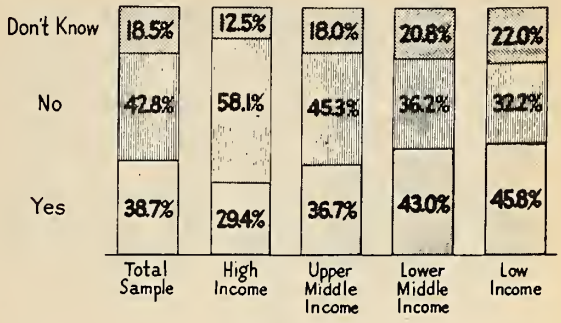


Chart 4

Michigan are already favorable to government-controlled medicine should be an exceedingly disturbing fact to you. When you add the 18.5 per cent who have not made up their minds, but who could be swayed either way, you should immediately see how dangerous this situation can be. By some manner or means you must win over slightly better than 61 per cent of these uncertain people—merely to be—*just on the safe side*.

As you might suppose, the percentage of those in favor of government control increases as you reach the lower income brackets. These are the people who are most easily swayed by the arguments of the surface-thinking, or surface-expounding, proponents of government control of medicine. These are the people, by and large, who from 1932 on for the next solid seven years were the principal beneficiaries of the largesse distributed by those who are now behind the proposal to take the control of medicine out of your hands ostensibly to put it into the hands of the people.

Here is another breakdown of this opinion which will be a constant threat to your profession until you do something more than argue defensively about it.

The only sweet note in this picture (Chart 5) is that the farmer, who has always been a rugged individualist, is less favorable to government control than are the professional, executive, clerical, white-collar class of worker. However, again you find that even in the farm population, a substantial group have not as yet made up their minds. Remember, too, that despite their customary attitude of independence, they as a class have been the recipients of a large and generous

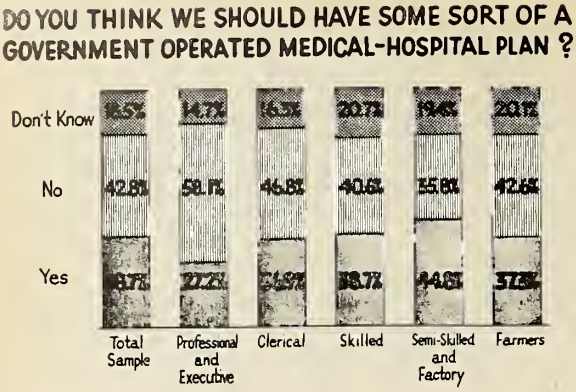


Chart 5

measure of government bounty. The farm block is always a strong and militant group which will continue to fight for special farm benefits. You know Washington as well as I do. You know the trading that goes on there. You know in principle that when you get things you have to give things. I don't know, and you don't know, whether the farmer would be willing to sacrifice his opinion on a question like this for a 10-cent higher ceiling price on a bushel of wheat or not. But you know, and I know, it's easier to give away something which you are uncertain you want than it is to sacrifice a princple or a system which you have definitely decided is right and desirable. By some manner or means the medical profession must *fix* in this 20 per cent of the farm mind, the conviction that government control of medicine will be as harmful to their best interests as you know it is to yours.

The import of Chart 6 is very clear. The two age groups—sixteen to twenty-four and twenty-five to thirty-four—are more in favor of government control than are the age groups thirty-five to forty-four and forty-five and over. These young people have grown up under the influence of a social program which began to be promulgated some twelve years ago in Washington. They have been more subjected to socialized thinking than have the older groups whose opinions and convictions were formulated under a different regime. Thus we have an added significance in this for you and your profession, because you are not only concerned with conditions as they exist today, but as they may exist five, ten, twenty years from today. The older groups shown on this chart as being less favorable to government control of medicine are those who will be the first to pass from the scene where opinion or a vote has significance. One of your jobs will be to build a back-fire to serve as a brake on the increased adoption by the younger people of that kind of theory which is inimical at its base to your desire to have the control of your business in your own hands.

Here is another angle on the attitude of people regarding the control of medicine (Chart 7). This angle is favorable to your side of the debate.

The left three bars were the chart which opened this presentation. The findings are repeated here so that you can compare them directly with the findings on this same question when these professions were hypothetically put under government control. The changed attitude of the Michigan public is immediately apparent. Of the 81 per cent who had said they would urge their children to enter these professions 45 per cent

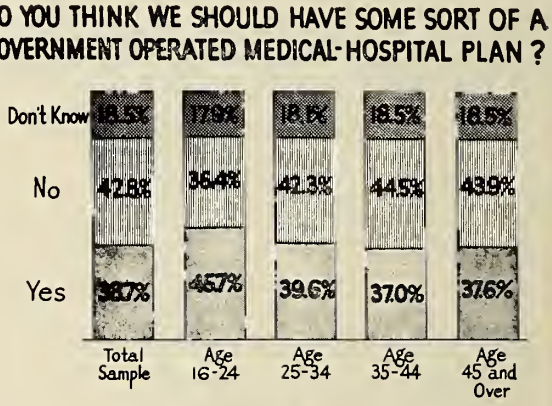


Chart 6

immediately changed their minds when we asked them if they would still so advise their children if these professions were under government control. The percentage of those who would veto this kind of a career for their children has increased almost three-fold. The percentage of those who have as yet arrived at no opinion on this question of a medical career under government control, has increased at least two and one-half times.

In our opinion, this constitutes one of the strongest indictments of government control of medicine and should be a very potent argument against it, particularly, if you win over the 19.6 per cent who as yet have no fixed opinion. The combination of these two groups would at least give you a clear majority. I personally would view with great alarm the future of medicine in

this country if it were established that the majority of our fathers and mothers were against having their sons and daughters enter the medical profession.

This question (Chart 8) gave the people a *choice* of five different ways of securing medical care. We have also incorporated in the bottom portion of this chart their votes when they were *not* given a choice but were merely asked, "Do you think we should have some sort of a government-operated medical-hospital plan?" The difference in their attitude under these two different conditions is immediately clear; whereas 38.7 per cent of all the people voted for a government plan when they were given no alternative except the present system, only 15.5 per cent of all the people voted for government control when they were given a choice of these *five* ways of securing medical-hospital care. Thirteen

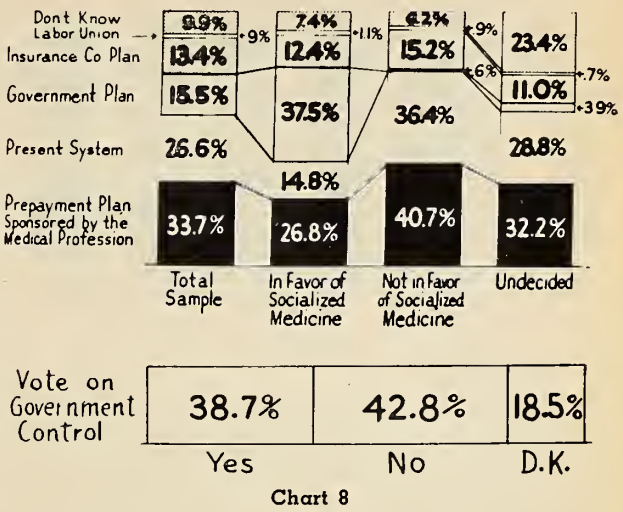


Chart 8

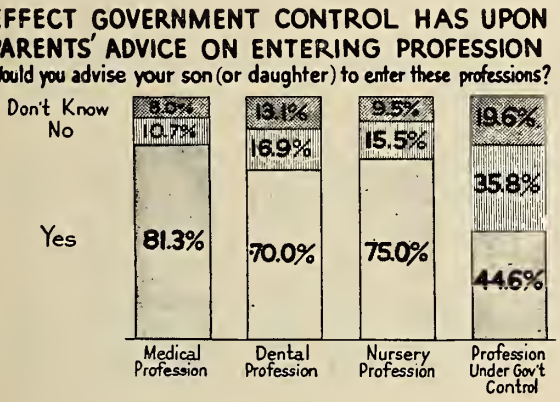


Chart 7

and four-tenths per cent would choose a plan offered by an insurance company; 26.6 per cent said they would stick to the present system.

An indication of great significance is the fact that 33.7 per cent of all the people, by far the greatest number, when given a choice, selected as most desirable a voluntary prepayment plan sponsored by the medical profession.

More significant still is the actual breakdown of the preference of the 38.7 per cent who had favored government control when they were offered a *choice* of securing medical care. Almost two-thirds of them desert government control in favor of other methods. Where do they go? One and one-tenth per cent choose a union plan. Twelve and four-tenths per cent feel they would be better off with the insurance companies. Fourteen and 8-tenths per cent choose the present system. The largest block, 26.8 per cent., of those who had voted for governmental control, prefer a professionally controlled prepayment plan *when offered a choice.* It shows further on the third bar that when given a choice those who had already expressed themselves as being *negative on government control* are more fixed in their opinions than those who had expressed themselves as being *in favor of government control.* Thirty-six per cent of this class would favor the present system and only six-tenths of 1 per cent would be satisfied to have medicine dispensed by government-controlled doctors.

It also shows that given a choice of these five plans, only 3.9 per cent of the undecided ones would favor government-controlled medicine. Again, we have the important factor of those who still have not made up their minds. If you can influence *favorably* the still undecided ones, the 23.4 per cent who *still* cannot make up their minds when offered a choice of these five plans, you will bring better than 50 per cent of the undecided 18.5 per cent votes, shown in the bottom horizontal bar, into your column. This would certainly be a step in the right direction.

We should not leave this chart without making another important observation. In a preceding chart and in its repetition here in the horizontal bar, it shows that only 39 per cent of the population of your state have voiced their opinion as being in favor of government-controlled medicine.

This is quite a bit below the number of people

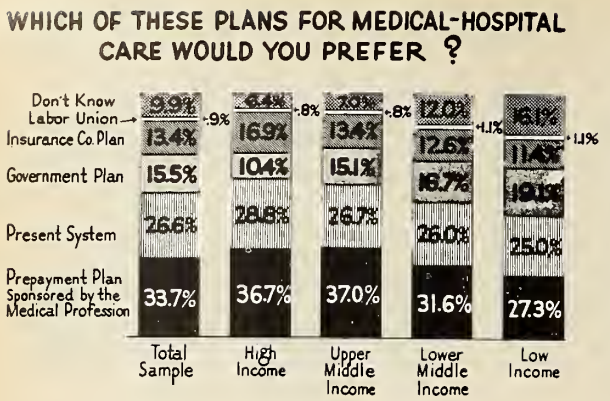


Chart 9

who have been of this opinion in other surveys that we have seen. You all remember the Fortune Magazine survey made some time ago, which showed that 74.3 per cent of our 130-odd million people were in favor of government-provided medical care through the collection of taxes. The answer to this question in any survey, of course, depends largely on the way the question is asked. It is one thing to ask average persons whether they would be in favor of government-supplied medicine for all the people, and quite another thing to ask them if they think the government should control medicine through a tax imposed upon its citizens. Practically all of the surveys that we have seen which have interrogated the people without weighting the question have shown responses favorable to government control in larger measure than the vote it received in Michigan. We ourselves conducted a similar survey in the State of California. It was delivered to the California Medical Association in January of this year and showed that 50 per cent of the people of California were in favor of government-controlled medicine, in contrast to 39 per cent for Michigan.

We believe that the activity of the Michigan Hospital Service and the Michigan Medical Service in this state has been largely responsible for the smaller number of people here who are willing to endorse medicine under government control.

Examining the state of Michigan further on these five different ways of securing medical-hospital care (Chart 9), we find that the high income and upper income brackets are more in favor of pre-payment plans sponsored by the medical profession than are the low middle income or the low income groups. This is, again, as you yourselves might have predicted.

There is a remarkable consistency in that portion of the total sample in all income groups that indicated they were perfectly satisfied with the present system of dispensing medicine.

This chart offers additional evidence that a plan of *government-controlled medicine becomes more and more appealing as income levels descend.* Corollary to this, the insurance plan becomes more attractive as you ascend from the lowest income to the highest income levels.

Also, as you yourselves probably would have anticipated, the lower you descend by income levels, the higher becomes that portion of the public which is unable to choose between these five ways of securing medical care. If you compare the "don't know" figures, however, with chart No. 4 in which we showed you that 20.8 per

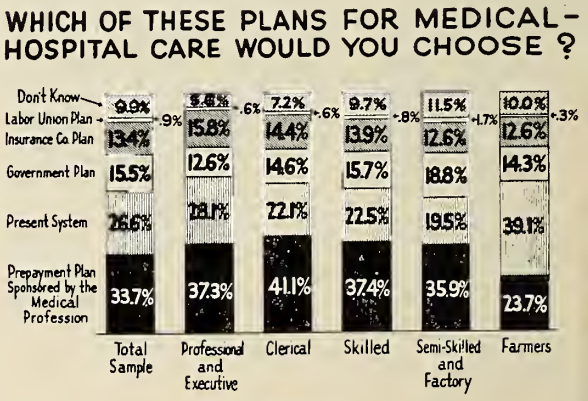


Chart 10

cent of the lower middle income group and 22 per cent of the low income group were unable to make up their minds about the desirability of government-controlled medicine, you will immediately see that given a *choice* of plans for medical-hospital care these people find themselves far more able to decide which is preferable.

By occupational groups the government plan is shown to peak in favor as you progress from group to group until you come up against the rugged individualism which has always characterized the American farmer (Chart 10).

The really encouraging significance from this chart is that given *a chance to choose,* even the semi-skilled and factory class who have been shown to be most in favor of government-con-

trolled medicine now register a 55.4 per cent vote for medical and hospital care dispensed by doctors of their own choice.

We have said before in this presentation it was our opinion that the activities of the Michigan Medical Service and the Michigan Hospital Service were largely responsible for the fact that fewer people in Michigan were in favor of government-controlled medicine than is true nationally. Chart 11, also, shows your efforts to date in this state have certainly been effective. When you consider the fact that only 34.9 per cent of the people of Michigan say they have heard of the Hospital Service Plan and yet remember that 23 per cent are already enrolled in Michigan Hospital Service, it seems to me to indicate an exceptionally high degree of conversion or sales performance. When you consider further that 23.8 per cent of the population say they have heard of the Medical Service Plan, and you know that 13.5 per cent of your population is enrolled in the Michigan Medical Service, it indicates that here, too, a truly remarkable conversion job has been done. Also, it indicates that the cause of medicine in Michigan will be further served, and greatly served, if the educational and promotional efforts of these two organizations are solidly supported by the whole profession extended and extended rapidly.

HAVE YOU EVER HEARD OF THE BLUE CROSS PLAN, MEDICAL SERVICE PLAN, HOSPITAL SERVICE PLAN?

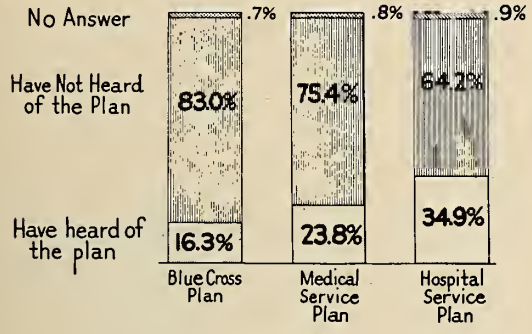


Chart 11

The *popularity* of the medical-hospital plan in Michigan under professional control and *not under the control of government* is amply evidenced by Chart 12. Seventy-nine per cent of the people to whom a plan of this kind was available have accepted it. This is a higher percentage than the very highest that I have ever seen as given for people favoring medicine controlled by the federal government. I would refer you back to the Fortune survey, which gave at that time that seventy-four per cent of the people were in favor of government-dominated medicine.

IS THE MEDICAL-HOSPITAL PLAN AVAILABLE TO EMPLOYEES WHERE YOU WORK?

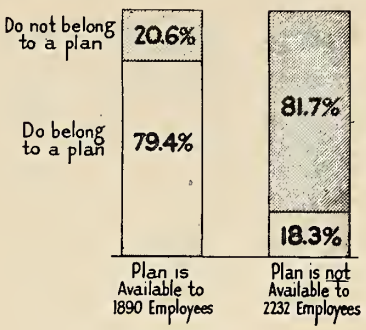


Chart 12

A further significance of this chart is the fact that a medical-hospital plan is not yet available to 45.5 per cent of the people of Michigan at their place of employment.

This is indicated by the fact that out of our total sample of nearly 5,000 people, there were 2,232 employes who were not able to secure group medical-hospital care at their place of employment.

Another fact that is not shown in this chart is that 16.2 per cent of the people interviewed did not know whether such a plan was available to them or not.

This is just another measurement of the educational and promotional job that lies ahead of you if you are to use every means at your command to successfully prevent the one thing I am sure everybody in this room does not want to see happen to the medical profession—and I am not talking about losing your stethoscope.

Chart 13 is further evidence of the remarkable success of those who have promoted medical and hospital care under voluntary control and operation. Forty-two per cent of Michigan's families have one or more members who are already enrolled in some type of medical or hospital plan of their own choosing. This ranges from a low of 27.9 per cent in the lowest income groups to a high of 49.3 per cent in the highest income groups.

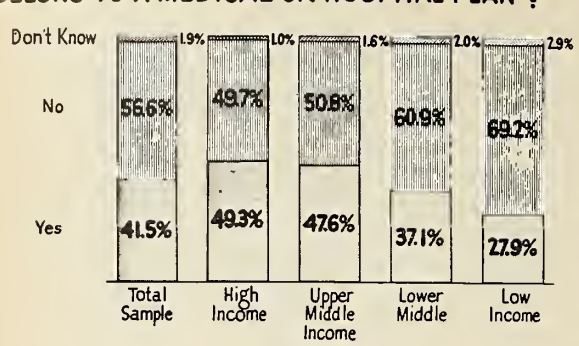


Chart 13

This also indicates that you should throw the greatest weight of your educational and promotional efforts against the lower incomes. Why? Because throughout this investigation they have shown the lowest acceptance of voluntary medical and hospital care. Because it is common knowledge that they are more susceptible than any other class to the principle of government control over anything—including the practice of medicine.

As I said at the beginning, we confined our attention in this presentation to those facts developed by the survey which we felt to be most interesting to this audience. In the complete job there are shown a great many additional facets of the complete Michigan thinking on both medical and hospital care. I don't know what distribution the Michigan Health Council is going to make of the bound copies of this investigation, but I would urge all of you to spend some time studying the other things which we have not had time to present here tonight.

Before I finish I would like to make several observations. I believe that this presentation has given you added confirmation of the dangers that actually confront your profession. The fact that the people of this sovereign state are less inclined than are the people of the nation as a whole to literally junk the fine work that they and all the other people of this nation say you have done and are doing, should not dull the edge of your fervor to protect the practice of medicine as you want it practiced. Unless you remain militant—and I don't mean argumentative—you may see, maybe not this year, maybe not next year, but ultimately you may see, regardless of Michigan's attitude, the threat that is now confronting medicine turn into an actuality.

You have seen in this presentation that the people of Michigan have some reservations on your profession. Certainly, to correct these impressions should be one of your first activities. I don't mean that you should persuade the public that they are wrong in their reservations about the practice of medicine. I mean that you should correct the things that lead them to this opinion. If it is necessary to police your profession to make certain that the Michigan public have no cause for thinking that your profession is dishonest, you should police it.

You should support, and actively support, any movement within your state which will begin to supply a perfect medical-hospital package for all the people of this state. The only way that you or your profession nationally can successfully combat the threat of government-controlled medicine is to provide through your profession and the hospital profession a package so perfect that government control and management will be clearly unnecessary.

Maybe I had better explain what I mean by a "package" for your profession. A package in our terminology is the thing you offer the public. To be most appealing to your public it should be as close to a completely and beautifully wrapped-up entity as you can possibly make it.

Senate Bill No. 1161 proposes such a "package"—a medical-hospital package for the people. You in your voluntary medical-hospital plans also have a package to offer.

Isn't it obvious that you are theoretically in competition with the package Senate Bill No. 1161 proposed? That being the case, you must make yours as complete, as appealing, as your competitor's, or you lose the sale.

The benefits you offer the people must be broadened to meet your proposed government competition. You must find a way through professionally controlled medicine and hospitalization to take care of all the people if you want these people to buy *yours* instead of the package numbered 1161.

If you immediately begin in a concerted manner to devote all of your available energies toward really winning this battle, the price paid for this survey will be a good investment. If you are lethargic about any possible activities that

may conceivably make this state safe for medical and hospital care professionally controlled, if you are complacent about what is going on in the rest of these United States of ours, then the price paid for this investigation automatically becomes a very poor investment.

I might even say—if the facts revealed by this investigation fail to spur you to ultimate effort in perfecting what you have here in Michigan—if they fail to make you just as active in fighting for and providing your kind of medicine on the national stage, the money spent for this investigation will not only be *wasted,* but your profession as you know it and as you want it—may ultimately be *laid* waste as well.

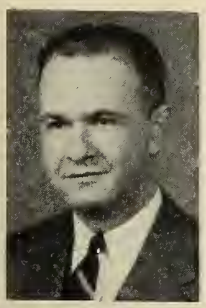
MSMS

Primary Atypical Pneumonia

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and

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Since primary atypical pneumonia has only in recent years been described, and is so commonly seen, a review of the subject is quite timely. It has become a serious problem in civilian life, as well as in the Armed Forces. This condition is, perhaps better known as "virus pneumonia," although no virus has been definitely isolated as the etiologic agent. The predominant features are the relative scarcity of physical signs and failure to respond to sulfonamides and penicillin. A clinical study of 165 cases will be given, including one case report with post mortem findings. The discussion will include a survey of the etiology and epidemiology of the condition, the clinical features, diagnosis including the roentgenologic characteristics, pathologic findings, and treatment.

■ Primary atypical pneumonia has received increasing attention as a disease entity within the last five years. It may be defined as a clinical syndrome which is characterized by an influenzal-like onset, patchy pneumonic signs, relatively normal white and differential blood counts, absence of any obvious bacterial etiology, definite roentgen findings of a patchy infiltration, and the failure to respond to the modern forms of chemotherapy in a satisfactory manner.

This is not a new disease as Owen[24] in his review pointed out that a similar pneumonia existed as early as the nineteenth century, which resembled the present form of primary atypical pneumonia. However, within recent years atypical pneumonia is appearing with great frequency, not only in civilian life, but especially in the armed forces where thousands of cases have been observed. In most hospitals and camps, it is appearing in far greater frequency than is lobar pneumonia. In Ford Hospital[15] from 1938 to 1941, atypical virus pneumonia was seen once to each six cases of pneumococcic pneumonia; and in 1942, there was a ratio of six cases of primary atypical pneumonia to every seven cases of pneumococcic pneumonia. In a recent report from the Station Hospital at Jefferson Barracks, Missouri, 1,862 cases of atypical pneumonia were reported in a fourteen-month period, June, 1942, to August, 1943, as contrasted with 62 cases of pneumococcic pneumonia for the same period at the camp.[33]

This disease entity has been referred to by many names, such as acute pneumonitis[2], broncopneumonia of unknown etiology[19], atypical bronchopneumonia with leukopenia[21], acute interstitial pneumonitis[30], disseminated focal pneumonia[9], virus pneumonia[22], and atypical pneumonia[5]. In March, 1942, the official military nomenclature was changed to primary atypical pneumonia, etiology unknown[26]. For convenience, this has been shortened to atypical virus pneumonia, or just atypical pneumonia[8]. No doubt the name "primary atypical pneumonia, etiology unknown" is best at present until the time comes when the etiologic agent is definitely described.

Etiology

Attempts at isolation of a definite etiologic agent have been for the most part unsuccessful. No known bacteria have been shown to be consistently present or to show any definite relationship to the disease. There has been a widespread lack of susceptibility of the usual experimental animals for the etiologic agent, if it be a single agent. It is interesting to note that ferrets, though susceptible to the influenza virus, are

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resistent to the agent of primary atypical pneumonia[13,31].

Numerous etiologic studies have been carried out. Francis and Magill[13] and Stokes, Kenney, and Shaw[31] recovered a filterable agent from the nose and throat washings of those who had the disease, but lost the agent after a few animal passages before it could be identified or proved. From four cases of primary atypical pneumonia Weir and Horsfall[34] isolated a filterable virus which produced lung consolidation in the mongoose. It was shown that contact mongooses developed the disease from infected ones and that convalescent mongoose serum protected against the disease or neutralized it, while normal mongoose serum did not. However, their results are somewhat inconclusive because of the failure to increase the virulence by serial animal passages and the resistance of some of their laboratory animals to infection.

Eaton, Back, and Pearson[11] isolated a virus similar to the virus of psittacosis. Favour[12] in his virus studies has shown the relationship between primary atypical pneumonia and ornithosis. Baker[3] has described an atypical pneumonia in cats which was also apparently contagious for man. On transmission to laboratory animals elementary bodies similar to psittacosis were found. Rake, Eaton, and Shaffer[27] have shown the similarities existing among the viruses of psittacosis, meningo pneumonitis, and lymphogranuloma venereum. Reiman[28] has an explanation which helps show the relationship and value of these virus studies. He has demonstrated that the viruses of psittacosis, of psittacosis-like infections, of chorio-meningitis, and of lymphogranuloma venereum cause meningitis, pneumonia, and skin granuloma, which are indistinguishable. Serum from numerous patients with primary atypical pneumonia fixed the antigens of these diseases. The Frei test was found to be positive in some cases of primary atypical pneumonia. This suggests that the viruses have a common origin in a parent strain, probably residing in birds or animals, which has become diversified by passage and adaptive residence in different hosts and tissues.

Other studies concerning the etiological agent are continuing. Dyer, Tapping, and Bengston[10] were able to isolate the rickettsia of Q fever in several cases of atypical pneumonia. However, to date, there have been no bacteria, no rickettsia, nor virus isolated which has been shown to be the cause of this type of pneumonia.

Epidemiology

Primary atypical pneumonia may occur in endemic or epidemic form. The widespread distribution must be due to the large number of unrecognized subclinical cases which are not apparent. The agent or agents producing this disease may set up a constitutional reaction of varying degrees of severity both with and without obvious chest signs. Careful studies have failed to reveal the existence of a nonhuman reservoir such as milk, water, ticks, chiggers, flies, and mosquitoes; obviously, the source of infection is contact with infected humans. While primary atypical pneumonia does not appear to be highly contagious, prolonged exposure and contact, such as occurs in hospitals, military barracks, and college dormitories, results in a high incidence of this disease. Although there is a sporadic occurence throughout the year, this type of pneumonia is more prevelant between the months of September to March. The literature reveals that the accepted incubation period is usually between one to three weeks, most likely about twelve to fourteen days. In our series, we found one case with an incubation period of four days, which is unusual.

Pathology

The gross and microscopic pathology of atypical pneumonia is rather definite, although the material for such observations is most scant since a patient rarely dies from this disease. Up to March, 1944, thirty-one autopsies from atypical pneumonia have been reported including nine fatal cases in infants described by Adams.[1,24]

The pathological changes described up to the present time have been very much the same with the exception of the cytoplasmic inclusion bodies in the bronchial epithelium reported by Adams and Saphir.[1,29] Reiman[28] has shown these inclusion bodies can be produced by hemophilus pertussis tularemia, toxoplasma, toxins, and irritant chemicals.

The pathological changes found in the lung consist of a patchy consolidation with areas of emphysema between small confluent areas of bronchopneumonia. There is inflammation along the entire respiratory tract including the minute bronchioles. Bacteria are extremely few in number. Microscopically, the involved areas of the

lungs show congestion and infiltration of the alveolar walls with monocytes, lymphocytes, and occasional neutrophiles. A similar reaction is present in the peribronchial and perivascular tissues. Many alveoli contain numerous large actively phagocytic monocytes, some eosinophiles, scant neutrophiles, fibrin, edema fluid, and red blood cells. Varying stages of the disease are seen including a tendency toward fibroblastic proliferation. Splenitis is usually present; there also may be an arteritis present in the lungs with thrombus formation. These pulmonary lesions are not pathognomonic of primary atypical pneumonia since similar changes are found in other interstitial pneumonias of known etiology.[14]

Clinical Picture

As was first described by Kneeland and Smetana[18] our cases fell into three groups on the basis of severity. The first group, comprising 75 per cent of our cases, is known as the mild type. 15 per cent of our cases were of the second group or severe form which involved large amounts of lung tissue and the patients were critically ill. The remaining 10 per cent composed the third group, or migratory type, which spread from one lung area to another, lasting for several weeks.

Our clinical study is based on 152 cases all verified by positive roentgen findings. In general, the onset of the disease was influenza-like with a sore throat, severe protracted headaches, chilliness, generalized aching, drenching sweats, severe cough in paroxysms, which, at first, was usually nonproductice. Sputum was rarely rusty or bloody, usually scant, but often produced in increasing amounts as the disease progressed. Fever ranged between 99°F. to 104°F. The pulse was relatively slow in proportion to the fever, and prostration was not great in the mild type of this illness. Pleuritic pain seldom was encountered; however, the cough was so severe that retrosternal soreness which was not related to respiration was common. Only those who were classified as the severe type demonstrated signs of toxicity with cyanosis, tachycardia, and dyspnea. Although abdominal distension was rare, soreness of the abdominal muscles due to coughing was extremely common.

The physical signs were few. Usually the patient was only moderately ill, conjunctival injection was present, and pharyngeal inflammation was slight. Physical signs in the chest were usually absent or very scant. In 30 per cent of our cases only a suppression of breath sounds or an unusual type of dry crackling rales heard at the end of inspiration were present early in the course of the illness. Yet nearly 70 per cent of our cases which showed no positive chest findings on physical examination early in the disease showed definite areas of a patchy consolidation on roentgen examination. By the time the fever, which usually lasted three to seven days in the mild cases, subsided, the physical signs of consolidation of a patchy type became evident. These signs persisted in the severe cases for several weeks. The disease usually ran its course in ten days to three weeks, though it was shorter in the mild cases and greatly prolonged in the severely ill patients.

Roentgen Findings of Atypical Pneumonia

The diagnosis of atypical pneumonia depends upon the clinical picture with associated roentgen findings. We are convinced that in no case could a diagnosis be made on either the clinical course or the roentgen findings alone. The information gained from roentgen examination is the deciding factor in arriving at the diagnosis. Most frequently there are thickened hilar shadows, usually one hilus showing more increase of density than the other. The thickening extends out from the hilus and is peribronchial in distribution resulting in accentuated lung markings. The distribution of the thickening in the early state is usually irregular and is not limited to one portion of a lobe, but is scattered and diffuse. There are diffuse patchy densities extending out from the hilus. Subsequent changes follow rapidly and localized areas of pneumonitis are seen which are fairly sharply defined, though their margins are feathery and hazy. The pneumonic infiltrations may be confluent or homogeneous, yet large areas of consolidation are not common. The lung markings are usually seen through the consolidation and give a characteristic striated appearance. The areas of increased density are most likely small lobular forms of atelectasis produced by blocking of the bronchi and bronchioles with exudate and swollen epithelium.

If the involvements are sufficiently extensive and confined to one lobe, the appearance is similar to lobar pneumonia. Likewise, there may be an associated thickening of the visceral pleura over the involved lobe similar to that found in

lobar pneumonia. In a small percentage of cases the involvement may be limited to the upper lobes and the resemblance to tuberculosis may be striking. In these cases repeated examination with serial films are required for a definite diagnosis.

The distribution of involvement may be central, confined to one or both lower lobes, or one or both upper lobes. Not uncommonly a single or multiple type of lesion progresses satisfactorily with clearing of the infiltration, but with little clinical improvement. Nevertheless, a subsequent film may show entirely new areas of invasion similar in all respects to the first involvement. In some cases, resolution may begin as early as the third day and in other cases extend beyond three weeks.

Laboratory Findings

The Laboratory data were of value in differentiating this disease from bacterial pneumonias. The white blood count in primary atypical pneumonia was relatively normal, being for the most part slightly above or below 7,000. The differential counts were also within normal range in most cases. In about one-half of the cases pneumococcus typing was done and in all instances failed to show the presence of pneumococci in the sputum. In two of our cases a search was made for agglutinins in the urine without success. Within the last year and a half, it has been demonstrated that the serum from patients with severe primary atypical pneumonia contained "cold agglutinins." This agglutination appeared several days after the onset of the febrile period, increased as the disease progressed, declined as the patient recovered, and eventually disappeared. The rarity of cold agglutinins in bacterial pneumonias and other diseases may make this test an important aid in identifying some of the cases of atypical pneumonia.[25] In those cases of our series in which sedimentation tests were done, 60 per cent showed an elevation of the sedimentation rate during the active process and a gradual return to normal as the disease subsided.

Complications

In our series of cases 29 per cent of the patients developed complications in the course of their illness. In the 1,862 cases at Jefferson Barracks, Missouri, previously mentioned, 36.2 per cent of those cases developed complications.[23] In our group, the most common complication was a reactivation of the pneumonic process which occurred in 10 per cent of the cases. Recurrences are infrequently mentioned in the literature and only one of our patients developed a recurrence one year after the original illness. In numerous reports, mention is made of the neurologic complications. Six of our patients developed an encephalitic picture characterized by severe headache, delirium, stupor, confusion, and neck rigidity. Other complications included eight patients who developed dermatitis medicamentosa due to sulfonamide therapy; one case of agranulocytosis due to sulfonamides; a case of acute nephritis due to sulfonamides; three cases of severe stomatitis and pharyngitis; one case of acute tonsillitis; three cases of severe asthma; seven patients had extreme respiratory distress, five requiring the use of oxygen and two the use of helium and oxygen; and one case of the Stephens-Johnson syndrome (conjunctivitis, stomatitis, and atypical pneumonia) which was further complicated by an encephalitic picture. No pleural effusions nor empyemas occurred. In the entire series of 152 cases, there were three deaths (one autospy obtained) with a mortality rate of approximately 2 per cent.

Differential Diagnosis

Even the most classical case of atypical pneumonia must be differentiated from other acute respiratory infections. Patients with pneumonia of bacterial origin such as pneumococcus, streptococcus, staphylococcus, tubercle bacillus, Freidlander's bacillus, and other bacteria are, in general, more severely ill, show frank signs of consolidation, have a high white count, higher fever, different roentgen findings, and the etiologic agent is readily isolated. Diseases caused by known viruses such as influenza, psittacosis, ornithosis, as well as rickettsial diseases and coccidioidomycosis, clinically resemble primary atypical pneumonia. These, of course, can be distinguished from it by isolating and identifying the etiologic agent in the laboratory. One must also differentiate atypical pneumonia from tonsillitis, tracheobronchitis, bronchiolitis, pharyngitis, the common cold, infectious mononucleosis, bronchiectasis, pleural effusion, atelectas, and carcinoma both primary and secondary.

Treatment

To date, there is no proven therapeutic agent which helps or definitely cures all cases of pri-

mary atypical pneumonia. In general, sulfonamide therapy does not affect the course of this disease. Many patients are made more ill by sulfonamides, and some develop toxic manifestations, as we observed in our survey. Both the clinical and roentgen diagnosis of atypical pneumonia is open to error. When the patient is ill with a suspected pneumonitis, sulfonamide therapy is indicated until pneumococcic pneumonia and other bacterial infections can be definitely excluded. When the diagnosis of primary atypical pneumonia is established, sulfonamide therapy should be discontinued.[16]

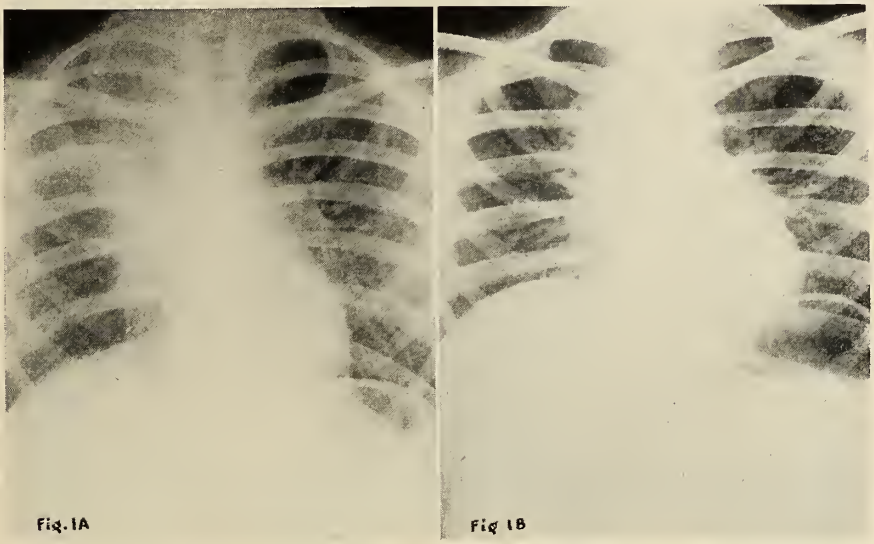


Fig. 1-A. Case 1:B.S. Roentgenogram taken January 26, 1942, showing marked increase in hilar shadows, more marked on the right. There is a diffuse irregular density spreading up from the right hilus.

Fig. 1-B. Case 1:B.S. Five days later on January 31, 1942, there was evidence of clearing of the density in the right upper lobe. The increased hilar markings are still present.

Convalescent serum has not been of any help. We used it in one case four times and this patient is the one who was subsequently autopsied. Young[35] has also used blood or plasma of convalescent patients in eight cases without any specific effects.

In one case, 400,000 units of penicillin were used over a three-day period with no beneficial results. Four other cases in the current literature have reported similar results with the use of penicillin.[7,20]

We have not used roentgen therapy in treating this type of pneumonia. Uhlman[31] has reported 50 cases of atypical pneumonia treated with radiation and noted rapid improvement in some cases. Offett[23] has reported ten cases with similar results. Correll and Cowan[6] reported twenty-three cases treated with x-ray with the distinct clinical impression that roentgen therapy reduced the total sick days, the total days of fever, and the days required to resolve the pneumonic process. We believe these results are promising but not conclusive. In our next series of cases we plan to give roentgen therapy a thorough trial.

At present, the only course to follow is one of symptomatic treatment; bed rest; fluids; diet as tolerated; antipyretics; sedatives; codeine for cough; expectorants if the cough is quite nonproductive; in some instances postural drainage is of value; steam inhalations; throat irrigations, and counterirritants to the chest. Cardiovascular stimulants are rarely indicated, unless there is associated heart disease. Oxygen should be used when indicated for cyanosis or respiratory distress. In occasional cases, the respiratory distress may be so great that helium and oxygen mixture should be used and even under pressure as reported by Barach[4] in four cases complicated with asthma.

Prognosis

Most patients with primary atypical pneumonia recover and the mortality rate is extremely low. Yet one must beware lest this disease in pandemic

form appear with new and so far unheard of virulence. This would be a catastrophe, since no beneficial therapeutic agent is available.

It is not impossible also for the development of virucidal chemical substances as sulfonamides which were bactericidal.

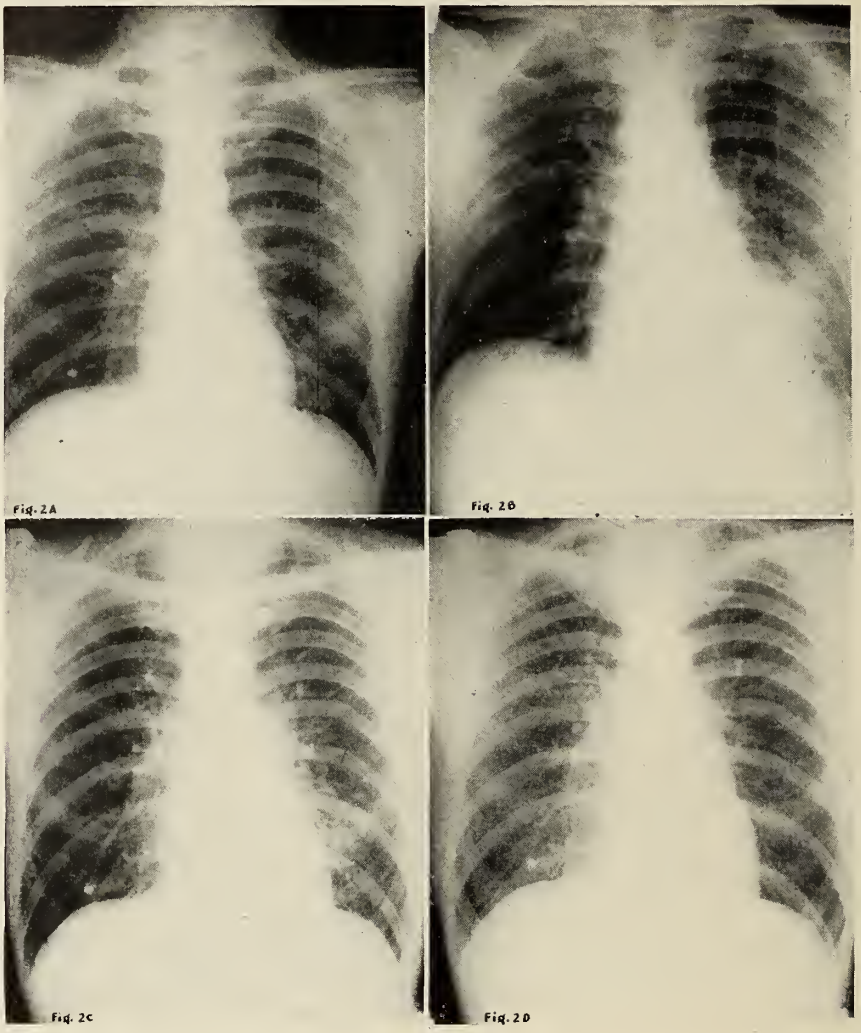


Fig. 2-A. Case 2:R.C. Roentgenogram taken January 14, 1943, shows a definite diffuse patchy density extending down and out from the left hilus.

Fig. 2-B. Case 2:R.C. Four days later on January 18, 1943, there was an increase in the amount and extent of thickening in the lower left lung field with coalescence of the densities to a considerable degree.

Fig. 2-C. Case 2: R.C. On January 28, 1943, there was definite improvement. The density shows clearing. Some thickening is seen in the right costophrenic angle.

Fig. 2-D. Case 2: R.C. On February 15, 1943, thirty-five days after onset of the illness, there was no evidence of pneumonic process; only coarse appearance of lung markings in the left lower lung field.

Let us hope that the progress in its therapy will be spectacular as was the story of pneumococcic pneumonia. The work of Francis and others on the production of immunity to the virus of influenza is a great step. From this may develop anti-virus for immunization and therapy.

Case Reports

The following are three case reports demonstrating the three types of atypical pneumonia previously described:

Case 1.—B. S., No. 1161, a nine-year-old girl, became ill on January 21, 1942, with headache, sore

throat, fever, chilly sensations, and a dry nonproductive cough. Her physician found diffuse rales on examination and felt she had a bronchitis. The temperature ranged between 99° F. and 103° F. She received symptomatic treatment and seemed to improve. Five days later, on January 26, she developed more severe paroxysms of coughing and expectorated a small amount of blood. On the same day, January 26, she was sent to St. Vincent's Hospital. On physical examination, there was decreased resonance in the right upper chest anteriorly with many crackling rales. There were a few moist rales throughout both lungs. The white blood count was 8,200 with 48 per cent polymorphonuclear cells. Several other counts ranged between 7,400 and 11,800 with normal differential counts. Sputum examinations for pneumococci and acid-fast bacilli were negative.

Admission roentgenograms on January 26 showed diffuse irregular density spreading upward from the right hilus region. There was also a marked increase in hilar markings particularly on the right (Fig. 1-A).

This patient was placed on therapeutic doses of sulfonamides. There was gradual improvement but on the fourth hospital day the temperature rose again to 102.3° F. The physical signs remained unchanged. The next day, January 30, she developed a severe maculopapular drug rash. Sulfadiazene was stopped and the remainder of her stay was uneventful. Roentgen examination on January 31 (Fig. 1-B) showed evidence of clearing of the density in the right upper lobe. The increased hilar markings were still present. Physical signs improved, and she was discharged from the hospital on the twelfth day.

This is an example of the mild type of primary atypical pneumonia. This is one of the earlier cases in our series in which sulfonamides were tried without beneficial results.

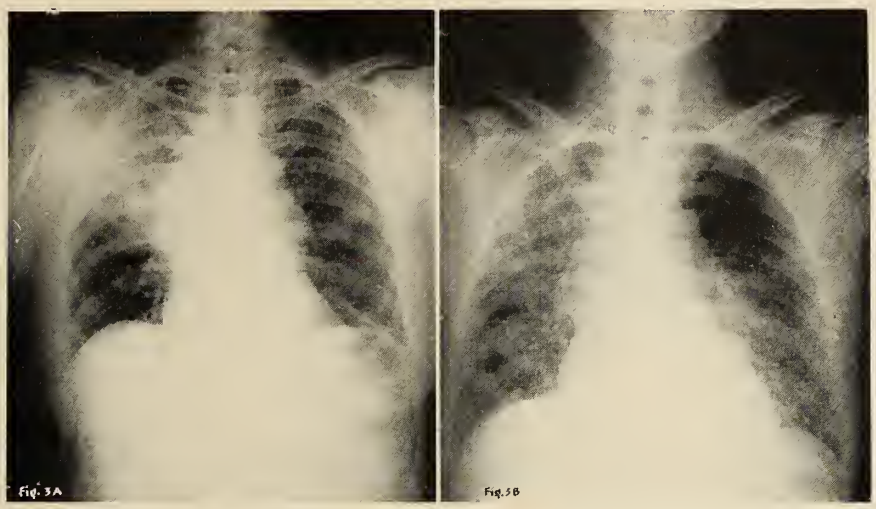


Fig. 3-A. Case 3: M.P. Roentgenogram taken December 29, 1943, shows marked increase in both hilar shadows especially on the right from which extends upward and out a marked irregular increase in density which has a patchy appearance. There is a small patchy density in the mid-lung field on the left.

Fig. 3-B. Case 3: M.P. On January 3, 1944, the amount of involvement in both lungs had increased, including almost the entire right lung and the lower one-half of the left. The irregular patchy character is more prominent. The change on the left side resembles that seen earlier in the upper right lung.

Case 2.—R. C., No. 871, forty-one-year-old white man, developed a severe nonproductive cough, fever, and chilly sensations four days prior to hospital admission. Sulfathiazole had been given by a local physician. On admission, January 14, 1943, the patient appeared moderately ill. The temperature was 103° F. Occasional dry crackling rales were heard posteriorly over the left lower lobe. On admission, sputum examination and typing for pneumococci were negative. The white blood count was 11,200 with 65 per cent polymorphonuclear cells. The urine showed albumen, granular casts, white blood cells, and sulfathiazole crystals. The admission chest film, January 14, showed a definite diffuse patchy density extending downward and outward from the left hilus (Fig. 2-A). In view of the history, physical and laboratory findings, and roentgen examination, the diagnosis of atypical pneumonia was made. Sulfathiazole which was given prior to admission was discontinued when the patient came on our service. General supportive treatment was carried out.

Four days after admission, January 18, the condition of the patient was unchanged. The white count was 13,800 with 71 per cent polymorphonuclear cells. Roentgen examination at this time showed a definite increase in the amount and extent of thickening in the lower left lung field with coalescence of the densities to a considerable degree. The remainder of the lung

appeared relatively clear (Fig. 2-B). Eight days after admission, the condition of the patient improved. The temperature gradually fell to 99° F. Films on January 28 also showed definite improvement, the density showed clearing, and accentuated lung markings were seen through the fading density. There was some thickening in the right costophrenic angle (Fig. 2-C).

Roentgen examination on February 15, thirty-five days after the onset of the illness, showed no evidence of the pneumonic process and only a slightly coarse appearance of the lung markings in the left lower lung field were seen (Fig. 2-D).

This is an example of the severe type of atypical pneumonia which gave little clinical evidence of its severity but showed continued evidence of its extent, roentgenographically.

Case 3.—M. P., No. 16160-279-44, a sixty-year-old white woman, developed an upper respiratory infection on December 15, 1943. Several days prior to hospital admission, on December 29, she became acutely ill with a high fever, generalized muscle and joint pains, profuse sweating, and a severe cough, which was slightly productive of a scant amount of mucoid sputum. On admission to St. Vincent's Hospital on December 29, she was acutely ill. There was marked injection of the pharynx. Coarse scattered rales were heard both anteriorly and posteriorly over both sides of the chest. No dullness to percussion was noted, but the breath sounds were increased and bronchial breathing was noted. Sputum examinations for acid-fast bacilli, pneumococci, and other organisms were negative. The urine showed no abnormality. Admission chest films on December 29 showed a marked thickening of both hilar shadows, especially on the right. The upper portion of the right lung showed a marked increase in density which was irregular and had a patchy appearance. There was a patchy thickening in the mid-lung field on the left (Fig. 3-A).

Roentgen examination five days later on January 3, 1944, showed the amount of involvement in both lungs had increased, and now included almost the entire right lung and the lower one-half of the left lung. On the right side the irregular patchy character was much more prominent than previously. The change on the left side resembled that seen earlier in the upper right lung (Fig. 3-B).

This patient was extremely ill and ran a stormy hospital course. The temperature remained between 103° F. and 105° F. for five days, remained at 102° F. for seven days, and became normal on the twelfth day. She was very cyanotic and required an oxygen tent for nine days. Transfusions with whole blood were used twice. Sulfadiazene was discontinued on the seventh hospital day after no apparent response was noted. She was discharged on the 21st hospital day with a normal temperature.

This is an example of a severe migratory type of atypical pneumonia in an elderly individual who was extremely ill, and failed to respond to sulfonamide therapy.

Summary

1. Primary atypical pneumonia is a definite disease entity. It is a very common disease and is becoming a serious problem in civilian life as well as in the armed forces. The full extent of its prevalence is not realized.

2. It is characterized by an influenza-like onset, headache, fever, severe paroxysmal cough, relatively normal blood picture, few early physical signs, and failure to respond to modern chemotherapy. The diagnosis must be verified by roentgen examination.

3. A clinical study based on 152 cases was reported with three case reports to demonstrate degrees of severity, the clinical course and roentgen interpretations.

4. A discussion of roentgen interpretations of primary atypical pneumonia was given.

5. The pathologic changes are a diffuse injection and inflammation of all the respiratory passages from the pharynx to the smallest bronchi, a patchy consolidation with areas of emphysema between areas of consolidation, and an atelectasis secondary to a bronchiolitis and peribronchiolitis.

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Medical service is a personal service, a matter of personal relation that it is impossible to supervise. Life or death or other serious consequences may rest upon the recognition of responsibility, tireless, careful observation, and the well-informed judgment of the physician. That is not a proper role for those who are emotionally unstable, the irresponsible, or those deficient in knowledge or judgment. The quality of medical service depends upon the quality of the profession giving that service. The present policy of discontinuing medical training except to those rejected from the armed forces and women is a serious error, and contrary to the advice of the best medical men.—R. L. SENSENICH, M.D., before Pepper Subcommittee on Health and Wartime Education.

What a Modern Army Health Service Should Be

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The orthodox concept that an Army Medical Corps is primarily concerned with the prevention of communicable diseases and the curing and healing of specific lesions and injuries is far too restricted. Unfortunately the greater part of the officer personnel are imbued with this idea as it is fostered by the traditional principles of medical education and the requirements of licensing bodies. It is not fully appreciated nor practised that the Army comprises a selected group each member of which is presumably above a certain minimum standard of physiological and psychological fitness. It is the duty of the Medical Corps to provide a Health Service in its broadest meaning and therefore must deal with soldiers from the anatomical, physiological, psychological and social points of view, always bearing in mind that he is being trained to fulfill a role entirely foreign to that of civil life.

■ THE invitation to address you on this occasion was received when I was on active military service with the Canadian Army. Although my leave of absence from McGill University was limited, its duration was not at that time definitely set. It was but natural, therefore, that my inclination was towards a phase of medicine in which I was most actively interested. Furthermore it must be appreciated that my concept of military health service is almost identical with what a civilian health service should be. We need not befog the issue by arguing what is the difference between such a service and health insurance and state medicine.

The present-day practice of medicine is bedevilled by two great deficits; namely, first, an improper distribution of medical practitioners and second, inadequate tools with which to practice our profession, particularly by those in slums, villages and rural areas.

A present-day medical student is trained to

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the level where all the most up-to-date methods of a modern teaching hospital are employed. When he leaves, after spending a longer or shorter period as an intern or resident, he naturally is dependent to a great extent upon these tools. He is, however, given the alternatives of practising in a large centre where these may or may not be available to him, or in a rural or semi-rural area where they are difficult of access and hence he reverts to practice his profession as in the horse-and-buggy days. The consequence is, on the one hand, an expensive medical service and, on the other, an inefficient although an honest and earnest one.

A further point in this background must be appreciated; namely, that the principal outlook of the medical practitioner is towards gross anatomical diseases and their therapeusis. This explains in large measure why surgical wards are full to overflowing and why so many patients, particularly women, suffer eventually from partial evisceration. The degree of responsibility which should be laid at the door of the state and provincial licensing examination bodies for this outlook is considerable.

In contrast to this organic disease concept it must be appreciated that over 50 per cent of the complaints for which patients seek medical advice cannot be attributed to demonstrable organic cause in the first instance, but are of the mind or the spirit. Furthermore, and additional but not inconsiderable number suffer from so-called minor complaints such as headaches, backaches, footaches, dysmennorrhoea, in which most medical practitioners have but little real interest and hence the populous waiting rooms and flourishing practices of the so-called irregulars.

A military or health service must be all-inclusive of all anatomical, physiological and psychological disabilities. It is true that it has to deal with a selected population not only as to age but also because the majority of those suffering from demonstrable organic diseases have been screened out by the induction and enlistment examinations. But, in spite of this screening, it is surprising how many mistakes are made, such as overlooking the importance of the history in chronic nontuberculous pulmonary diseases and that large group of so-called "rheumatic" conditions, and the overemphasis upon a systolic murmur without any supporting evidence, and also the undue apprehension attributed to a slightly elevated systolic blood pressure without corresponding change in the diastolic pressure. It is in these duties that the medical officer finds himself in a quandary, as he is called upon to make serious decisions without sufficient experience in this group of potentially healthy personnel to be on firm ground. The group of medical officers who are called upon to carry out these duties have probably one of the hardest and also most important jobs in the whole corps. A recruit wrongly rejected is a vital loss of manpower, while one accepted who should not be, eventually represents a great loss in money and precious training time of skilled personnel. Therefore, these officers should be specially selected and trained for this most important but withal monotonous task as it is so different from their traditional role. The same applies to analogous practice in industry.

There was a time when it was considered to be the medical officer's duty practically to assign the recruit to a certain corps or service. This might have been satisfactory, although I doubt it, when the art of war was relatively simple as compared to the multitudinous jobs which the present-day soldier has to do. His physical, mental and emotional qualities must all be taken into consideration. This requires a particular discipline and is *in toto* beyond the capacity of the medical officer. It is his duty to describe honestly the soldier's physical condition in degrees of capacity based on a combatant soldier's requirements; in other words, his functional attributes relative to the perfect man. His adaptability, craftmanship, intelligence quota, literacy, are assessed by others and while his emotional background is judged by the psychiatrist he is allocated to the job he can probably do best. This process is a combined effort by all concerned; but, in the last analysis it is the Army Examiner who is the judge of the soldier's destiny. This whole undertaking cannot be a perfunctory process placed in the hands of unskilled and haphazard personnel. It is one of the most crucial assessments in the whole fabric of the Army as the results determine the quality of the fighting arm as well as the smooth and intelligent functioning of supply, armour, communications, and the hundreds of special jobs which must be done with as near perfection as possible in a successful Army the personnel of which is divis-

ible into the killers and the tradesmen. The former are many times indistinguishable from the latter, but the whole mosaic must be perfect and complete.

To separate or divorce what we call "Personnel Selection" from a composite organization which includes the Medical Corps is the epitome of stupidity. Through the whole of a soldier's career his physical or emotional conditions are subject to fluctuations of excellence; so is his usefulness to pull his weight to ultimate success. He is being trained or is trained to be a soldier and the longer this process lasts the more useful he will be in some arm of the Service, as many of the skills are interchangeable.

The next chronological step in the duties of the Medical Corps, although inverse or, perhaps, intermediate in regard to age of experience, is that of the regimental medical officer. He is really the key man and his counterpart in civilian life is the general practitioner and all that this should imply. We should visualize what these duties are. He has under his immediate responsibility the health and happiness in a new society of approximately one thousand fighting men. His charges, until they become veterans and have completely dissociated themselves from civilian life, are in the process of continual training. They are, therefore, needful of both physical and psychological surveillance. The physical efforts are more than most have been accustomed to and of a different variety. Muscles that were silent from disuse suddenly become articulate in protest to unusual effort. The recruit is apprehensive of an unknown world and these aches and pains afford a focus upon which he concentrates to provide him with a tangible explanation for his apprehension. It must be appreciated by the medical officer that his charges are a picked group of men and women in the heyday of life, and that all obvious anatomical and even suspicious emotional diversions have been already eliminated.

But the proper duties of the regimental medical officer does not stop here. A citizen army, whether volunteer or drafted, is in its very essence a social eruption for its members. They have left a life of seeming independence with friends and family within an accustomed environment, to be translated into an entirely different society. It is a more civilized one although directed to killing and being killed. The recruit does not appreciate as yet the wonder of this comradeship of arms. He is fearful and anxious not only as to his own destiny but also for his family and dependents. It is here that the commanding and medical officers may be at a loss as to how to cope with these situations which, although individualist, in their multitude become a veritable mass. These officers are not trained, nor have they time or facilities, to handle this multitude of diverse problems. It has been traditional to consider that the Padre is the man to solve all matters of emotion which are supposed to stem from the so-called soul as represented by faith. But faith in what? These problems are not of religion but usually in a biological and economic sense, of the earth—earthly. They stem from the mundane but personal things of a man's life. It is in regard to these aspects that the Medical Corps must be broad and as comprehensive as in civil life, in fact, more so.

The so-called social sciences have a great role to play and their disciplines must be used by the realistic Medical Corps not as subservient to medicine but as a partner, both working to the same end, namely, the complete physical and emotional equilibrium of the perfect soldier. The multitude of problems which the trainee and fighting soldier have to bother them are not of the body alone, but are in great measure from beginning to end of the emotions also. The trainee taken as a mass wants to know a thousand and one things which no medical officer could know the technique or have the facilities to explain. The social worker can. I would here emphasize the fact that these officers must be professionally competent and not amateurs, and may be of either sex. In fact, a female social welfare officer may, under certain circumstances, be better able to solve problems which are of the most difficult character and with their solutions soldiers are made. It must be reiterated that this social work cannot be carried out by well-wishing amateurs. This work requires well-trained professional personnel. It is different in some ways from traditional civilian requirements as is that of the medical officer.

It is interesting and withal at times amusing to look back on the development or progress of our concepts of many of the causes of casualties from the Army. A casualty may be defined as a soldier—officer or other rank—who has ceased to be useful in the role to which he has been trained

and cannot be usefully employed in any other capacity. But the published casualty lists usually enumerate those who have had traumatic injuries or die from severe infections such as malaria, typhus, infectious jaundice, scrub typhus, dysentery, venereal disease, et cetera, although most of these have accounted for many times more manpower days lost than have battle injuries. In addition, there is that group of disabilities which are seldom referred to in official lists, namely, the psychosomatic syndromes, the frankly psychiatric casualties, and those variously grouped under battle-fatigue, exhaustion, and other synonyms, which would imply that they occur only in front-line soldiers. Nothing could be farther from the truth. It is true that these conditions do occur in front-line soldiers and to a great degree are amenable to prompt treatment by competent psychiatrists or medical officers who, although not so trained as specialists, have an understanding of the problems involved and their solution.

Any active army in the field depends upon reinforcements of manpower as well as armour and munitions. This manpower supply can only come from the manhood of the country. It is well known that approximately 50 per cent of the rejections of recruits is on account of emotional or psychiatric reasons and that during training and in preparation for battle a large percentage of those who fall by the wayside and have to be reduced in grade or even discharged from the army suffer from the same disabilities. The primary origin of these casualties is to be found in family and social reasons. The old adage that "everyone is crazy but thee and me, and thou a little bit" has been well demonstrated in the past five years. The incidence of these conditions is much lower in the voluntary recruits than in draftees. It would, therefore, seem obvious that motivation to fight for one's country with a single-mindedness of purpose is prompted by an emancipation from those personal and social ties or emotional restrictions which loom so large in the oedipus domination. Many of these individual problems are amenable of solution but not immediately by the medical officer. If he has the concept he does not have the time or the facilities to pursue the investigation to its ultimate conclusion. Unfortunately in many instances he does not appreciate the full import of the situation and deals with the soldier in a manner which is antagonistic, or to say the least, unsympathetic and devoid of understanding. Unfortunately many of the traditions as to the proper behaviour on the part of combatant and medical officers towards the recruit stems from the hard-boiled attitude in vogue in the mercenary or regular army. This does not go in a citizen army where every man is potentially as good as his fellow in civil life but may have trials, troubles and phobias which loom large in his cosmos in this transition from a peaceful, law-abiding person to a "killer."

Therefore for a large per cent of the casualties in training and in battle, the medical officer does not have the proper therapeutic armamentarium. His pills, potions and surgical procedures may do more harm than good as they will confirm the emotional or harassed patient in his belief or give him reason to be convinced that his vague pattern of symptoms are indicative of an organic disease the apprehension of which still further aggravates his disability. All such cases can be best handled by a judicious and sympathetic hearing by the medical officer and a proper concept that all complaints do not necessarily have an organic foundation. At this point he should have available his professional social worker who would carry on the history and by a well co-ordinated organization delve into the social and family background. Illness at home, an impending baby, economic stress, a bad crop, long silence from wife or sweetheart, and dozens of other causes may mean the difference between unrest and worry and the happy warrior. This provision of social medicine must not be perfunctory or casual and carried out by the amateur. It must be well organized and have its contacts and ramifications over the lands bordering the seven seas. A soldier in Africa, Italy, France, England, or the South Sea Islands may be the victim and officially, through his officers to whom he looks with faith and confidence, contact with his home or other source of discomfiture must be possible. This is equally applicable to the boy from Iowa in Florida, from Maine in California or from Quebec in British Columbia. This means a well-knit organization not separate from, but intimately associated with, the medical officer, in fact an integral part of the Medical Corps. I know there is a fear on the part of some that the social workers will become subservient to the medical officer and

not have a free hand in their professional sphere. If such were the case, the medical officers would be chauvinistic and intolerable pedants and should be properly disciplined by superior authority. On the other hand, the social workers must appreciate that they are part of a team and are not commissioned as independent therapeutic agents. It must be appreciated by the social workers that they have ofttimes in civil life made themselves suspect by their unprofessional arrogance and have antagonized their medical colleagues by untactful criticism as often as medical reaction and indifference have seemingly ignored their proper place in the common goal to enhance human health and happiness.

In the third phase of the Medical Corps we find its officers more at home in their traditional role—namely, the diagnosis and therapy of organic disease. It is interesting but understandable that this is the type of work to which they all aspire. For the Army's point of view, if we are realists, it is of lesser importance than the first or second, whereas to the humanist it takes precedence. The usual visceral diseases, if they have a disabling aftermath, require expert diagnosis and therapy before discharge, but these cases are relatively few as the army population is a well-selected one and falls in the age groups when such diseases are few unless they follow rheumatic fever or tuberculosis contracted in service. As already pointed out, the majority of medical conditions fall into the infectious disease group. For these the primary responsibility of the Medical Corps is prevention. It is the duty of every medical officer to contribute to this end and there is no excuse for failure whether it be due to venereal disease, tetanus, scarlet fever, mumps, smallpox, diphtheria, malaria, dysentery, typhoid fever, infectious jaundice, typhus, scrub typhus, plague, yellow fever, or what have you. The occurrence or continuance of any of these must be viewed as an acknowledgment of failure. I appreciate that Utopia cannot always be attained, but a fatalistic attitude or one that shifts responsibility to someone else's shoulders cannot be accepted by higher authority. It is true that the medical officer has but limited command, but he has authority none the less. He is adviser to the commanding officer whether of company, regiment, brigade, division, corps or army. If his advice is not followed, he can and must appeal to higher authority. Many manpower days are lost from preventable diseases, and the essence of the reduction of these is through rigid discipline of indicated techniques. It is one of the first duties of the medical officer to see to it that all protective inoculations are meticulously carried out. To my mind any breach of this duty should be the subject of disciplinary action of which there is far too little in the medical services. An error of judgment is but human, a neglect of an order is a crime.

This is the first war where a psychiatric branch of the Medical Corps has really come into its own. For security reasons the magnitude of its responsibility will not be stated, but it is most important to appreciate that in a well-organized service its salvage value to the fighting forces is almost equal to that accruing from the prevention of infectious diseases. A trained soldier or veteran returned to the firing line is equivalent to one and a half recruits. These cases all come under the notice of the regimental medical officer in the first instance and unless he is knowledgeable of what can be done and how to do it, he is delinquent of his duty. The same may be held in civilian practice.

Contrary to conditions in civilian life, the surgeon has a numerically minor role in handling of disabilities. It is true that those due to enemy action are more often a menace to life and limb. Further they are more harassing to the emotions of relatives and the soldier is apt to be exposed to more suffering. There is also an appeal to the spectacular in the action of sulpha drugs, penicillin and blood substitutes, but these are all of little avail unless proper surgical procedures are carried out. This requires sanity and a knowledge gleaned from the past experience of wars which is too often neglected. But in this aspect I am probably getting beyond my competent role. I would crave, however, to pay a sincere tribute to our young surgical colleagues who have pressed forward to a short distance behind the firing line to bring their skill to the wounded soldier. Their exposure to the dangers of the fighting man has probably done as much, through treating wounds early, to reduce the eventual morbidity and mortality as have the other agents already mentioned. But these triumphs of medical service are restricted to the privilege of the relatively few and are in large measure made possible by the devotion and courage of the general practitioner of the Medical Corps, namely,

the regimental officer. It is an unfortunate commentary on the Medical Profession that so many crave to serve in a military hospital where the work is humdrum and easy as compared to their colleagues in the regiment, field ambulances and field surgical units. This indicates a rather arrogant attitude which should not be encouraged, particularly amongst the young, and has an important lesson for those who aspire to direct the changing order in civilian practice. I have already stated that there is a disproportion in the distribution of professional facilities. It may be taken today as an axiom that the consultant is one with all the modern technology of medical practice at his immediate command. Without these he would be lost. So it is in the army, and according to his training the young medical officer wishes to serve in a hospital, as he has at home, where most things are done for him by technicians, officers, sergeants, corporals and privates. He is provided with a service which few have had before and which he will crave when he returns to civil life and without which he will not be happy.

The fourth stage of the medical service is one that is not properly appreciated by our administrators and so-called statesmen, namely, the preparing of the soldier for return to civil life. Ten per cent or thereabouts of our men and women have been transformed into a new society and have lived in it for a longer or shorter period. All have psychologically changed and many also have changed physically. In their reorientation to civilian life the medical profession must play an important part. It is not enough to hold or consider that we are only interested in their diseases and mutilations. Their whole health, physical, psychological and social, is our grave concern. Furthermore, this concept must be put into action as soon as a soldier is injured to such a degree that he is probably no longer likely to be an efficient soldier, or when the order to cease firing is given. It would seem obvious that this can best be done by those who helped train him to be a fighter or commanded him during battle and looked after his illnesses or injuries and know his psychological makeup as compared with well-intentioned civilians, even veterans of the last war. I cannot overemphasize the role which the Medical Corps should play along with their fellow officers in other corps. I know you have regulations to this end, but see to it that the medical profession does not falter or fail in this great opportunity to prove their worth and fulfill the trust which they abrogate to themselves by virtue of their Hippocratic charter.

Woven through what I have said there is implied an analogy or counterpart to what civilian practice should be. There are fundamental principles in a well-organized army health service which are equally applicable to civilian practice. We civilians restrict ourselves too rigidly to the diseases to which we can give a specific organic basis and forget the emotions and environment of the man whom it may or may not inhabit. The medical profession has to my mind failed in its trust because it has not demanded proper tools for the less privileged of their colleagues. Further, it has not viewed its domain as "health" as distinct from "disease." As pointed out for the army, less than fifty per cent of all disabilities including battle casualties are attributed to demonstrable anatomical lesions or diseases, so it is in civilian life and we pay little interest to these other unfortunates.

The Army Medical Corps is concerned with clothing, nutrition, housing, recreation, family relations, economic conditions and a multitude of ancillary factors as well as disease which interferes with the well-being and production of the fighting man. Why should this be not so in civilian practice? The answer is that we as individuals are not paid for these details, but only to correct the effects of their abuses. This would never be tolerated in the army. The battle would be lost as it almost was before it had begun. So it is in civilian life. We do not have to fuss and fume about state medicine or health insurance. Let us pattern our programme on the concept of a military health service. We as a collection of individual medical practitioners can so conceive a medical Utopia or democratic medical Society where there is security for all, arrogance for none and comradeship and loyalty to those who have proven their worth to guide us to a promised land. These moses's must, however, be of our own choosing and not of a Pharaoh who is influenced by political exigencies; in other words, patronage and a resulting majority of favorable votes.

Andrew P. Biddle Endows Postgraduate Medicine

The late Andrew P. Biddle, who practiced medicine in Detroit for over fifty years and who died August 2, 1944, at the age of eighty-two years, generously endowed the Michigan State Medical Society Foundation for Postgraduate Medical Education and the Department of Postgraduate Medicine of the University of Michigan. Together with his wife, the late Grace W. Biddle, our Past President willed the bulk of his estate of over $80,000 for the continuation of postgraduate medical work.

The House of Delegates of the Michigan State Medical Society, at its Grand Rapids Session of September, 1944, adopted a resolution memorializing Dr. and Mrs. A. P. Biddle. The Council authorized the transfer of sums immediately payable and those to come from the residue of the estate to the MSMS Foundation for Postgraduate Medical Education. In all, the Postgraduate Foundation of the State Society will eventually receive approximately $40,000. This great sum, together with the original contribution of $10,000 made to the MSMS Foundation by the Council several years ago, will bring the Foundation total to approximately $50,000.

The Michigan State Medical Society Foundation for Postgraduate Medical Education was created by The Council in May, 1942. Dr. Biddle's great contribution justifies the foresight of The Council. His extreme generosity should serve as a noble example to be followed by other Doctors of Medicine and laymen interested in continuing medical education.

A. S. Brunk

President, Michigan State Medical Society

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President's



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EDITORIAL

WHAT THE PUBLIC THINKS OF US

■ The survey of public opinion of the Michigan medical profession has many lessons to which we must give heed. Probably the most gratifying response shows the high esteem in which the profession is held: 81.3 per cent would advise a son to enter the profession; 91.6 per cent thought that the majority of doctors were doing a good job for the public; 60.8 per cent thought that doctors are as honest as they should be in their dealings with patients; and in choosing between forms or plans of medical service, 60.3 per cent selected that sponsored by the medical profession (33.7 per cent a medically operated prepayment plan, and 26.6 per cent the present private practice plan of paying the doctor for services as rendered). This is good reading, but why not 100 per cent?

They think well of us.

Eighty-one and three-tenths per cent would advise a son to enter the profession. Of the 18.7 per cent who would not so advise, 10.7 per cent do not "care for the profession," 1.7 per cent mention the doctor's bad moral characteristics or ethics (the only group opposing because of bad opinion), and 0.9 per cent are anti-medicine from a religious or other reason. Forty-five and three-tenths per cent think the profession too difficult, 21.5 per cent think the son should make his own decision, 3.0 per cent don't know why they so advise and 5.2 per cent gave no answer. The balance think the profession overcrowded, expect changes after the war, think the responsibility too high, or give other miscellaneous reasons. Better than one out of six of those voting against the profession have a reason demanding our attention, and efforts to improve. They may be wrong and we right, but this is their opinion, and something has prompted it.

They think we are doing a good job.

Ninety-one and six-tenths per cent of the people in Michigan think we are doing a grand job. Four and two-tenths per cent have not made up their minds and 4.2 per cent of the public do not think the doctors are doing a good job. Why? Of this 4.2 per cent 24.2 per cent think doctors overcharge, 21.3 per cent think doctors keep their patients waiting too long. Ten and one-tenth per cent think doctors do not take time to diagnose properly, 5.8 per cent think doctors are dishonest, and a like number think they do not do enough research, are not intelligent enough, and a similar number think that the doctor's first interest is not in curing the patient. Four and three-tenths per cent think the profession is a racket and a like number complained, of all things, that the doctors neglect the people in favor of the Army. Three and four-tenths per cent think doctors prescribe unnecessary or expensive treatments.

Are we honest?

In sampling opinions of 4,968 persons, 1,393 were found who do not believe that doctors are as honest as they should be. This is a reaction scarcely expected, and one that must be closely studied. We as a profession cannot expect to fully succeed with 28.2 per cent of the population not trusting us. Every doctor must examine himself and find and eradicate the offending trait. Here are the reasons given. Forty-one per cent of the 28.2 per cent think doctors do not tell the truth, don't give all the facts, don't give a true diagnosis, or won't admit they do not know what is wrong. Eighteen and two-tenths per cent think the doctors overcharge, rob the public, are too aware of social position, or use the profession for social advancement. Fourteen and five-tenths per cent think that doctors give or order too many and unnecessary expensive treatments. Five and eight-tenths per cent charge the doctors are indifferent or neglectful, don't take enough time for a proper diagnosis, or spend enough time with their patients. Seven and eight-tenths per cent think doctors are dishonest for the patient's own good. The balance come under the complaints that they frighten patients, exaggerate, create fear, or refuse to call specialists or counsel. A few think medicine a racket, and some of course do not know why they think the doctors are dishonest (5.1 per cent).

Government or private control of medicine?

Two thousand one hundred twenty-six persons, or 42.8 per cent of the people queried, do not favor a government-operated medical-hospital plan, and 38.7 per cent think we should have it. This is a margin in our favor, but not so wide that it could not be changed, and changed quickly: 2,126 against 2,064. Of those favoring government control 54.9 per cent think it would provide necessary care for all, and especially the poor; 12.4 per cent think it would cost less. Seven and two-tenths per cent think the government should have control, and a similar number think it would be a more satisfactory plan. Three and five-tenths per cent think it would raise the standard of the medical profession and 3.2 per cent think it would improve public health. It is interesting that 3.2 per cent of those opposed to government control think it would lower the standards of the medical profession.

This brief analysis shows there are too many people that do not like us, and the reasons they give. These can mostly be eradicated by individual and by concerted effort. The future of the practice of medicine depends upon this effort being made. It must be by individual effort—made by EVERY Michigan, or American, Doctor of Medicine!

REPLIES TO CRITICISM

■ The Public Opinion Survey just finished gives us some criticism that obviously is readily answered. First that the doctors keep patients waiting too long in their offices, or in responding to calls. This comes from 21.3 per cent of the 4.2 per cent who do not think we are doing a good job under these wartime conditions. Of course they may refer to other times and conditions, but now with the shortage of doctors of medicine for the home services, it is surprising how well the people are cared for.

Some men try to see all patients by appointment, and there is then a necessary delay. Frequently appointments are for two and three weeks in advance. Many of us have abandoned the appointment scheme (except for special out-of hours cases), and have the patients wait their turn, explaining kindly and carefully that a third more patients can be seen that way—it is true at a discomfort—but the patients can see that the doctor is working at high tension and doing his best. It is surprising how many patients comment on the stress, and marvel how the doctor keeps up the pace. This definitely spikes the complaint of needlessly keeping people waiting too long.

Each of us must study the other complaints as they relate to us, and the cure must come from within the ranks of the profession.

THE SEVENTY-NINTH ANNUAL SESSION

■ The Seventy-ninth Annual Session of the Michigan State Medical Society is now history. There were fewer in attendance than was hoped, but those who did attend saw one of the greatest postgraduate medical conferences. Michigan's plan of many out-of-state speakers draws attendance, and brings to us the outlook and thought of medical leaders throughout the nation. This year was up to the high standard of the past, in spite of the difficulty of promising to participate in a program months in advance, when wartimes make all things uncertain. (One of our speakers this year was ordered overseas just the week before our meeting, but sent his paper along, and it was well received.) Great credit is due to our secretariat, and the Scientific committee for a grand job.

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A slight rise in temperature and a persistently elevated pulse rate, without apparent cause, after the fourth of fifth postoperative day, should stimulate a search for other signs of latent thrombosis.

• • •

Intravenous morphine is often sufficient for the cleansing of burns or for painful dressings.

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ACS, anti-reticular cytotoxic serum of Bogomoletz, is reported capable of stimulating the body to resist the degenerative changes of age by stimulating the reactivity of the connective tissue cells.

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Selected by W. S. Reveno, M.D.

Michigan Health Council

The progress of the Michigan Health Council during its first year has been rather typical of that of new enterprises, in that it has been concerned largely with organization, with the definition of objectives, and with the laying of groundwork for future constructive activities. The objectives already have been reported, and the organizational work has consisted primarily of the incorporation of the Michigan Health Council as a nonprofit agency and the opening of offices, with an executive director, in the Washington Boulevard Building, Detroit.

Most significant for the future, however, are such Health Council projects as a survey of public opinion in Michigan which has just been completed. Before initiating the survey, much consideration was given by the Health Council to the problems which confront the medical profession and the hospitals in their relationships with the public. It was felt that certain unsympathetic public opinion, as well as much of the public support for such measures as the Wagner-Murray-Dingell Bill, could be traced directly to lack of public understanding of the profession and the hospitals.

The Health Council members decided that a joint program of education to correct public misconceptions would be desirable. It was further believed that the profession and hospitals would be interested in ascertaining just what kind of services the public wants, and in considering the steps that might be taken toward a better meeting of public desires. Factual information was lacking; what was known about public attitudes was largely a matter of hearsay or opinion.

To get the facts, a survey was authorized in the spring of 1944, the General Research Bureau of the advertising firm of Foote, Cone & Belding (formerly Lord & Thomas) was hired for this purpose, the field work took place during the summer months, and the report on the survey was completed and reported upon in Grand Rapids at the 79th Annual Session of the Michigan State Medical Society.

In general, the survey shows that the medical and related professions are held in high esteem by the public, that the people are seriously concerned with the economic problems involved in obtaining adequate health care, that there is broad public demand for pre-payment programs to assist in meeting these problems, and that only a small minority of the people favor compulsory governmental programs when voluntary pre-payment, especially under professional sponsorship, is available to them.

The survey contains a wealth of information of value to each of the Health Council's parent organizations. The collective implications of the survey findings will be examined by the Health Council, and it is likely that definite recommendations will be made.

Meanwhile, the Health Council already has taken the initial steps toward public education. Under sponsorship of the Council, Mr. Floyd E. Armstrong, professor emeritus of economics and finance for the Massachusetts Institute of Technology, has delivered approximately 30 public addresses before groups throughout Michigan. In these talks he particularly emphasized the advantages of the private practice of medicine and the merits of the voluntary hospitals. Plans currently are being made for an active itinerary of further talks by Prof. Armstrong, by Prof. Paul D. Bagwell, head of the department of speech and dramatics of Michigan State College, and by other qualified laymen.

Among other educational activities already initiated by the Health Council might be listed the distribution and preparation of literature and other printed material to doctors and hospital administrators, and the establishment of a preliminary library of material on medical and health economics for the use of physicians, hospital administrators, health service plans and other interested organizations.

It will be recalled that the Michigan Health Council originally was called into being because there existed a need for an agency to serve as a clearing house for the four sponsoring organizations and for the presentation by these organizations of a united front on matters of common interest. In serving this purpose, which is largely intangible, the Health Council has begun to demonstrate what is believed to be definite usefulness.

For example, a special committee of the Health

(Continued on Page 1008)



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MICHIGAN HEALTH COUNCIL

(Continued from Page 1006)

Council is studying a proposed amendment to the Constitution of the State of Michigan which would create a comprehensive compulsory social insurance system, including health insurance, in this State. This committee has analyzed the proposal thoroughly, and will be in a position to make immediate recommendations should it appear that the amendment proposal actually will be carried to a popular vote.

The Health Council further has considered and indorsed plans for the survey of the hospitals of Michigan which is being sponsored by the Michigan Hospital Association. Another matter under current consideration is a proposed bill for the licensing of hospitals in Michigan, which also is a project of the Michigan Hospital Association. Various other matters have been referred to the Health Council for review and comment by the sponsoring organizations.

On a broader scale, the effectiveness of the Council thus far and its promise for the future have led to a feeling that similar organizations could be of value to the health professions throughout the United States. The Council has made preliminary plans for contacting the medical professions, the hospitals, and the pre-payment plans of other states with a suggestion that consideration be given to the development of local health councils. The establishment of a national co-ordinating agency, perhaps to be known as the American Health Council, would seem to be an ultimate goal.

The sponsors of the Michigan Health Council, as will be remembered, are the Michigan State Medical Society, the Michigan Hospital Association, Michigan Medical Service, and Michigan Hospital Service. The first two organizations are represented on the Health Council by three members each; the two pre-payment plans each have representation by two members.

For the Michigan State Medical Society—A. S. Brunk, Md., C. E. Umphrey, M.D., and Wm. J. Burns.

For the Michigan Hospital Association—Graham L. Davis, L. V. Ragsdale, M.D., and L. S. Woodworth, M.D.

For Michigan Medical Service—R. L. Novy, M.D., Jay C. Ketchum.

For Michigan Hospital Service—William J. Griffin, and W. H. Lichty.

In addition, the Health Council is so constituted that representation may ultimately be given to other groups, and some such other groups—notably, the Michigan State Dental Society—already have expressed their interest in the Council's activities.

The officers of the Michigan Health Council are: President, A. S. Brunk, M.D.; Vice President, Graham L. Davis; Secretary, William J. Burns; and Treasurer, J. C. Ketchum.

Thus far, the Health Council has been supported financially by contributions of $5,000 each from the Michigan State Medical Society and Michigan Medical Service, with an equal amount from the two hospital organizations. Total contributions thus amount to $20,000. Of this amount, some $9,000 is set aside as the expense of the survey of public opinion, and disbursements have amounted to $3,038.63 as of September 12. Slightly more than half of the disbursements have covered fees and travel expenses connected with public addresses sponsored by the Health Council, and the balance has gone into salaries, office rent, and incidental expenses. The unexpended balance on Sept. 12, 1944, amounted to $7,842.91.

What the Michigan Health Council has sought is a constructive program of mutual benefit to the medical profession, the hospitals and the public. The projects undertaken to date should be of definite help toward the realization of that program.

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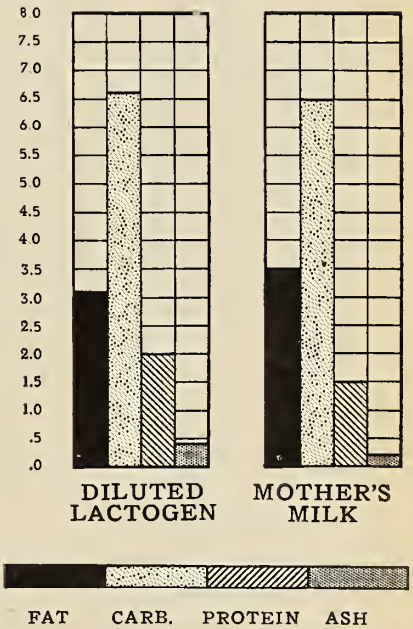
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Clinical Pediatrics, p. 156.



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Michigan Physicians Committee Organized

The Michigan Physicians Committee, a branch of the National Physicians Committee, was organized at a meeting held in the Book-Cadillac Hotel, Detroit, on Wednesday, October 11. Representatives from MSMS Councilor Districts in all parts of the State were present at the meeting to hear Edward H. Stegen of Chicago outline the activities and the program of the National Physicians Committee.

Officers of the new organization were elected. C. E. Umphrey, M.D., Detroit, was chosen as Chairman and Wm. M. LaFevre, M.D., of Muskegon, was selected as Vice Chairman. The Secretary is E. R. Witwer, M.D., Detroit, and the Treasurer is W. D. Barrett, M.D., Detroit.

The organizational meeting was called at the suggestion of The Council of the Michigan State Medical Society. Present at the Detroit meeting were:

E. F. Sladek, M.D., Traverse City, Chairman and O. O. Beck, M.D., Birmingham, Vice-Chairman of the Council; Councilors C. E. Umphrey, M.D., Detroit; R. S. Morrish, M.D., Flint; O. D. Stryker, M.D., Fremont; Wilfried Haughey, M.D., Battle Creek; R. J. Hubbell, M.D., Kalamazoo; Dean W. Myers, M.D., Ann Arbor; A. B. Smith, M.D., Grand Rapids; E. R. Witwer, M.D., Detroit; and P. L. Ledwidge, M.D., Detroit, Speaker of the MSMS House of Delegates. Also present were President A. S. Brunk, M.D., Detroit, Secretary L. Fernald Foster, M.D., Bay City, and immediate Past-President C. R. Keyport, M.D., of Grayling.

Others at the initial meeting of the Michigan Physicians Committee were:

L. W. Hull, M.D., Detroit; H. H. Gay, M.D., Midland; L. C. Harvie, M.D., Saginaw; R. L. Wade, M.D., Coldwater; H. R. Moore, M.D., Newaygo; C. A. Paukstis, M.D., Ludington; E. A. Oakes, M.D., Manistee; E. J. Bolan, M.D., Suttons Bay; Fred Drummond, M.D., Kawkawlin; F. J. O'Donnell, M.D., Alpena; Wm. M. LeFevre, M.D., Muskegon; J. E. Mahan, M.D., Allegan; C. K. Stroup, M.D., Flint; L. W. Howe, M.D., Marquette; J. S. DeTar, M.D., Milan; D. T. MacDonald, M.D., Monroe; E. T. Morden, M.D., Adrian; J. H. Burley, M.D., Port Huron; L. S. Woodworth, M.D., Detroit; A. V. Wenger, M.D., Grand Rapids; C. A. E. Lund, M.D., Middleville; H. G. Huntington, M.D., Howell; T. Y. Ho, M.D., St. Johns; K. T. McGunegle, M.D., Sandusky; Wm. J. Burns, Executive Secretary, Michigan State Medical Society; and J. A. Bechtel, Executive Secretary, Wayne County Medical Society.

Sponsoring Committee

All Doctors of Medicine present at the Detroit meeting of October 11 will form a Sponsoring Committee for the Michigan Physicians Committee. In addition, the following representative physicians in various parts of Michigan, designated by MSMS Councilors, have also been invited to become members of the Sponsoring Committee:

V. M. Moore, M.D., Grand Rapids; Wm. A. Hyland, M.D., Grand Rapids; J. Milton Robb, M.D., Detroit; G. L. McClellan, M.D., Detroit; B. I. Johnstone, M.D., Detroit; Arch Walls, M.D., Detroit; R. C. Connelly, M.D., Detroit; S. W. Insley, M.D., Detroit; T. K. Gruber, M.D., Eloise; R. L. Mustard, M.D., Battle Creek; R. A. Springer, M.D., Centerville; L. E. Holly, M.D., Muskegon; T. P. Treynor, M.D., Big Rapids; G. B. Saltonstall, M.D., Charlevoix; C. S. Clarke, M.D., Jackson, Luthur W. Day, M.D., Jonesville; Paul Engle, M.D., Olivet; W. E. Barstow, M.D., St. Louis; G. H. Frace, M.D., St. Johns; A. L. Arnold, Jr., M.D., Owosso; H. M. Best, M.D., Lapeer; E. W. Blanchard, M.D., Deckerville; E. C. Sites, M.D., Port Huron; N. L. Lindquist, M.D., Manistique; W. H. Huron, M.D., Iron Mountain; C. T. Menzies, M.D., Iron Mountain; H. L. Sigler, M.D., Howell; J. E. Church, M.D., Pontiac; M. M. Wilde, M.D., Warren; W. D. Barrett, M.D., Detroit; T. I. Bauer, M.D., Lansing.

"The work of the Michigan Physicians Committee," stated Chairman Umphrey, "will begin at once and will be patterned after the modern outline of activity developed by the National Physicians Committee and explained at the Detroit meeting by Mr. Stegen. The Michigan Physicians Committee will work in the interest of better Medicine, the preservation of all that is valuable in the present American type of private practice, together with the encouragement of supplemental features, where needed, to the end that good medical care is distributed to all in this State who need it. The Michigan Physicians Committee is dedicated to a progressive program of modern medical service to all."

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3. **ADDITIONAL MEDICATION:** Synthetic vitamins as indicated, orally or parenterally.
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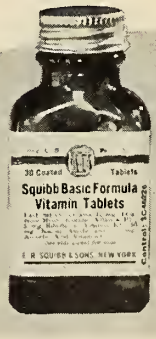
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COUNTY SECRETARIES CONFERENCE IN GRAND RAPIDS

Eighty persons attended the County Secretaries Conference held September 27, 1944, on the occasion of the 79th Annual Session of the Michigan State Medical Society in Grand Rapids.

The interesting program included an outline of "Health Insurance Proposals in Canada" by F. A. Brockenshire, M.D., Windsor, Canada, immediate Past President of the Ontario Medical Association; "Nebraska's New Medical Practice Act," was explained by M. C. Smith, Lincoln, Nebr., Executive Secretary of the Nebraska State Medical Association; and "The Michigan Picture in Medicine," an outline of current events of interest to county society officials and members, was presented by L. Fernald Foster, M.D., Bay City, MSMS Secretary.

T. Y. Ho, M.D., St. Johns, Chairman of Secretaries, acted as toastmaster.

The thirty-one county society secretaries present at the Conference were:

E. B. Andersen, M.D., Dickinson-Iron; Helen S. Barnard, M.D., Muskegon; Paul H. Bassow, M.D., Washtenaw; E. W. Blanchard, M.D., Sanilac; E. S. Carr, M.D., Chippewa-Mackinac; R. C. Conybeare, M.D., Berrien; C. C. Corkill, M.D., St. Joseph; Frank L. Doran, M.D., Kent; Ray M. Duffy, M.D., Livingston; F. Mansel Dunn, M.D., Ingham; L. Fernald Foster, M.D., Bay-Arenac-Iosco; C. L. Grant, M.D., Manistee; J. Bates Henderson, M.D., Huron; T. Y. Ho, M.D., Clinton; W. O. Jennings, M.D., Kalamazoo; Wm. S. Jones, M.D., Menominee; R. Bruce Macduff, M.D., Genesee; John J. McCann, M.D., Ionia-Montcalm; A. H. Miller, M.D., Delta-Schoolcraft; H. R. Moore, M.D., Newaygo; E. S. Parmenter, M.D., Alpena; G. B. Saltonstall, M.D., Northern Michigan; L. G. Sevener, M.D., Eaton; John C. Shoemaker, M.D., Tuscola; R. W. Spalding, M.D., Van Buren; Stanley A. Stealy, M.D., North Central; C. B. Toms, M.D., Luce; Arch Walls, M.D., Wayne; Herbert S. Wedel, M.D., Barry; Wm. Westrate, M.D., Ottawa.

Executive Secretaries included:

Wm. J. Burns, Lansing; Sara M. Burgess, Flint, and James A. Bechtel, Detroit.

Presidents of County Medical Societies who attended were:

Harold H. Gay, M.D., Midland; L. W. Hull, M.D., Wayne; C. P. Lathrop, M.D., Barry; Michael R. Murphy, M.D., Wexford.

MSMS officers who attended included:

E. F. Sladek, M.D., Chairman of The Council, and Councilors W. E. Barstow, M.D., Dean W. Myers, M.D., O. D. Stryker, M.D., C. E. Umphrey, M.D.

Editor W. B. Harm, M.D., of the *Detroit Medical News,* was present.

Others who attended included:

Congressman Bartel J. Jonkman, Grand Rapids; Prof. Floyd E. Armstrong, Mt. Pleasant; Prof. Paul D. Bagwell, E. Lansing; Lt. Governor Eugene C. Keyes, M.D., Dearborn; Auditor General Vernon J. Brown, Lansing; Mildred Busch, Lansing; Charles A. Coghlan, Detroit; H. Earle Correvant, Lansing; C. V. Costello, M.D., Holland; Carleton Dean, M.D., Lansing; Supt. of Public Instruction, Eugene B. Elliott; State Health Commissioner William DeKleine, M.D., Lansing; State Representative Andrew Bolt, Grand Rapids; L. W. Faust, M.D., Grand Rapids; N. K. Forster, M.D., Hammond, Indiana; President of Indiana State Medical Association; Perry W. Greene, Grand Rapids; Dr. Thomas G. Hull, Chicago; John D. Karel, Grand Rapids; Jay C. Ketchum, Detroit; G. L. McClellan, M.D., Detroit; W. B. McWilliams, M.D., Maple Rapids; R. L. Novy, M.D., Detroit; Katherine Post, Lansing; L. A. Potter, Lansing; Carl S. Ratigan, M.D., Dearborn; W. S. Reveno, M.D., Detroit; H. L. Sigler, M.D., Howell; Lillian R. Smith, M.D., Lansing; E. C. Texter, M.D., Detroit; R. V. Walker, M.D., Detroit; A. V. Wenger, M.D., Grand Rapids; G. E. Winter, M.D., Grand Rapids; F. J. Busch, M.D., Saginaw and L. J. Goulet, M.D., Ludington.



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Woman's Auxiliary

OUR NEW PRESIDENT

The Woman's Auxiliary to the Michigan State Medical Society welcomes its new president, Mrs. Horace L. French of Lansing, Michigan.



MRS. H. L. FRENCH,

Mrs. French was born Lela Witter at West Branch, Michigan, May 11, 1902. She attended the University of Michigan 1918-22, receiving an A.B. degree with a major in mathematics. Her senior year she became a member of Phi Beta Kappa and Sigma Xi, national honorary societies. Following her graduation she taught mathematics in the Portland (Mich.) High School 1922-24, and the East Lansing High School 1924-25.

She is the wife of Horace L. French, M.D., also a University of Michigan graduate (1921) and a Fellow of the American Academy of Pediatrics. Their daughter, Carolyn, is a freshman at Michigan State College and son Lawrence (better known as Larry) a student at West Junior High School.

Mrs. French is a charter member of the Woman's Auxiliary to the Ingham County Medical Society (1926) and has served as secretary, treasurer, auditor, finance, welfare, and program chairman of that organization. In the state auxiliary she has been successively, secretary, treasurer, vice president and finance chairman, president-elect and finance chairman. Her other activities include membership in the St. Lawrence Hospital Auxiliary, Board of Directors of the Greater Lansing Visiting Nurse Association (president 1942-44), and the Lansing branch of the Board of Directors of the Michigan Children's Aid Society.

MABEL BOUGHNER, *Press Chairman*
(Mrs. Walter H. Boughner)

—— Subscribe to The Bulletin ——

THE PRESIDENT'S MESSAGE

The officers and chairmen of the Woman's Auxiliary to the Michigan State Medical Society for the year 1944-45 extend greetings and best wishes for a successful year to each county auxiliary and unaffiliated member.

The accomplishments of last year were outstanding, let us put forth every effort to maintain that record of achievement.

The same projects will again command the attention of the auxiliary. We will continue to aid in the recruitment of students for the United States Nurse Cadet Corps, and to explain to our friends, neighbors and clubs the basic reasons for the stand of the medical profession on proposed legislation. Cognizant of the importance of the following health projects we will co-operate with the Michigan Tuberculosis Association on the Radio Speech Contest and urge our members to participate in the work of the Women's Field Army.

Believing *Hygeia* an important aid in interpreting the ideals and aims of the medical profession to the public, we will make every effort to secure a wider distribution of this magazine. In addition we implore every member to interest herself in the problem of juvenile delinquency. Where there is a community group attempting the solution of this problem, offer your co-operation. Where there is no such group but a need for one, start its organization. Surely, auxiliary members can—and will—make a definite contribution toward eradicating this canker from American life.

Your officers and chairmen offer our assistance and will welcome any opportunity to be of service. With the continued efforts of each member the coming year can only show further evidence of the usefulness and value of the Woman's Auxiliary.

LELA W. FRENCH,
President

—— Subscribe to The Bulletin ——

ATTENTION COUNTY PRESIDENTS AND CHAIRMEN OF STANDING COMMITTEES

The Mid-year board meeting of the State Auxiliary is tentatively planned for the Monday following Thanksgiving in Detroit. Members will be notified of the exact time and place as soon as arrangements are completed.

County Presidents and Chairmen of Standing Committees are urged to submit plans for the coming year to Mrs. H. L. French, 1620 W. Main St., Lansing, Michigan, by November 5. These reports are the basis of Michigan's report, which Mrs. French will present at the National Conference of Presidents and Presidents-Elect to be held in Chicago, November 16 and 17.



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Other clinicians[4], investigating "twenty-five women under close institutional observation", noted that "with a tampon of proper size, absolute comfort and complete control of the flow can be obtained . . . the obvious advantage of the small, medium and large sized tampon of the particular brand (Tampax) is to be noted."

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(1) Am. J. Obst. & Gyn., 35:839, 1938. (2) West. J. Surg., Obst. & Gyn., 51:150, 1943. (3) Clin. Med. & Surg., 46:327, 1939. (4) Med. Rec., 155:316, 1942.

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COUNTY AND PERSONAL ACTIVITIES

Wm. S. Reveno, M.D., Detroit, is the author of an original article, "Thyrotoxicosis Treated with Thiouracil," which appeared in the JAMA, September 16, 1944.

* * *

F. A. Rawling, M.D., of Ann Arbor is co-author of "Bronchial Asthma as a Manifestation of Sulfonamide Sensitivity" which also appeared in the same issue of JAMA.

* * *

Don H. Duffie, M.D., Central Lake, Michigan, has an article, "Hemoglobin Estimation by the Revolutionary Colorimetric Method," under Physical Notes and Suggestions of New Instruments, in JAMA of September 9.

* * *

Walter Brunk, a brother of President A. S. Brunk, M.D., and C. F. Brunk, M.D., of Detroit, died October 6 after a year's illness. The late Dr. Brunk was a practitioner of dentistry in Detroit. The Society's condolence is extended to the family of the late Dr. Brunk in their bereavement.

* * *

Paul D. Bagwell, Head of Speech Department at Michigan State College, addressed a panel at Central Methodist Church, Lansing, on October 25. His subject was "Report on the Michigan Survey of Public Opinion re Medicine."

* * *

The Michigan Society of Neurology and Psychiatry held its first regular meeting of the 1944-1945 season in Detroit on September 28. Dr. George H. Preston, Commissioner of Mental Hygiene for the State of Maryland, addressed the Society on the subject "Psychiatry and Demobilization."

* * *

"Implications of Nutrition and Public Health in the Postwar Period" was the subject of an all-day conference arranged by the Children's Fund of Michigan in Detroit on November 3. An excellent program was developed with ten speakers from various parts of United States and Canada. The medical profession was well represented at this conference.

* * *

The Michigan Pathological Society held its regular bi-monthly meeting in Grand Rapids on September 27, 1944, in conjunction with the meeting of the section on Radiology, Pathology and Anesthesia of the Michigan State Medical Society. A seminar on "Lesions of the Male Genital Tract" was conducted by Dr. Robert A.

(Continued from Page 1018)

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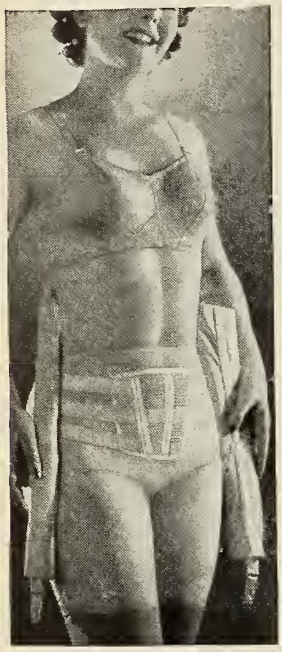
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(Continued from Page 1016)

Moore, Professor of Pathology, Washington University School of Medicine, St. Louis, Missouri. An afternoon session was held at the Pantlind Hotel at which 46 members and guests were present. Following dinner at the Blodgett Memorial Hospital, an evening session was held which was attended by forty members and guests.

* * *

EMIC Program Extended to One Year.—The emergency program for maternity and infant care for servicemen's families has been extended to include health supervision for their first year.

The care may be given either in the doctor's office or in child health conferences, depending on the operation of the state plan.

How much will be paid the doctor, how and when he can collect it, and such minor details are still somebody's secret.

* * *

The Wayne County Medical Society recently sent the following postal card to all its membership:

"Are you satisfied that present conditions will last forever?

"What do you think medical practice will be after the war? How about *your* practice?

"Do you know 'What's going on?' What are you doing about it?"

"This is a reminder of your Society's opening meeting next Monday night. It's a program you can't afford to miss."

* * *

A. S. Brunk, M.D., President of the Michigan State Medical Society, has been appointed by Governor Kelly to a Special Committee to study needs and resources of Michigan hospitals. The committee work will be financed by the W. K. Kellogg Foundation, the Commonwealth Foundation of New York and the National Foundation for Infantile Paralysis. Michigan and two other states will be surveyed as models for the rest of the nation. Other physicians appointed to the committee include: A. C. Furstenberg, M.D., Ann Arbor; E. W. Norris, M.D., Detroit; and Bruce H. Douglas, M.D., Detroit.

* * *

Radio broadcasts sponsored by the MSMS Radio Committee (Russell N. DeJong, M.D., Chairman) during October were:

October 5—Dr. Jerome W. Conn, Associate Professor of Internal Medicine in the University of Michigan Medical School: Fat People and How They Get That Way.

October 12—Dr. Samuel W. Donaldson, Roentgenologist, St. Joseph's Mercy Hospital, Ann Arbor: The Role of X-Rays in Emergency Cases.

October 19—Dr. Julius M. Wallner, Assistant Professor of Psychiatry in the University of Michigan Medical School: The Patient.

October 26—Dr. James H. Maxwell, Associate Professor of Otolaryngology in the University of Michigan Medical School: Deafness.

(Continued on Page 1021)

(Continued from Page 1018)

Percy Jones General and Convalescent Hospital, Battle Creek, is sponsoring weekly staff conferences every Monday at 7:30 p.m. These programs, to which all members of the Michigan State Medical Society are invited, are held in the Officers' Conference Room. C. Howard Hatcher, M.D., Chicago, spoke on November 6; L. H. Newburgh, M.D., Ann Arbor, presented "Hyperglycemia in Obese Persons" on November 13. The dental service sponsored the program of November 20. Frederick A. Coller, M.D., Ann Arbor, will talk on "Treatment of Carcinoma of the Colon" on November 27.

* * *

Hopkins says socialized medicine not necessary.—Socialized medicine will not be necessary but public medical services must be made available to all income levels to keep Americans healthy in postwar years, Harry L. Hopkins, President Roosevelt's close friend and adviser, stated in a signed article in the November issue of *The American Magazine.*

In his article entitled "Your Job After the War," Mr. Hopkins, who frequently has reflected administration views, advances a formula for achieving prosperity and a higher standard of living and stresses the need for better housing facilities, education and health.

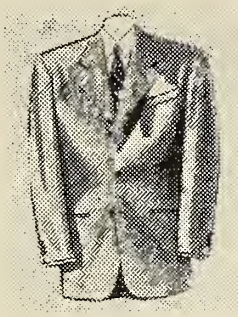
"Adequate medical care must be available to all income levels," he writes. "To work, men must be well. Sickness is a job-loser. The health of the American people can be improved through health insurance and increased public services. We do not need socialized medicine to do the job."

Mr. Hopkins does not elaborate on this particular subject. However, in his over-all plan for postwar prosperity he proposed reduced taxation, encouragement of small business and free enterprise, higher wages, broader social security benefits, preservation of the competitive system, and government spending only to supplement individual effort.

* * *

The Lapeer County Medical Society complimented David H. Burley, M.D., Almont, eighty-one years of age, and Henry G. Merz, M.D., of Lapeer, seventy-five years old, both of whom have completed more than fifty years of practice, and Frank A. Tinker, M.D., of Lapeer, eighty-five years old, who has been in practice sixty years. The testimonial banquet was held on August 29 at the Lapeer Country Club. President D. J. O'Brien, M.D., presided. H. B. Zemmer, M.D., toastmaster, introduced the three honor guests and also Councilor R. S. Morrish, M.D., Flint, MSMS Secretary L. Fernald Foster, M.D., Bay City, MSMS Past Presidents Herbert E. Randall, M.D., Flint, and P. R. Urmston, M.D., Bay City, and W. H. Marshall, M.D., Flint.

The three honor guests are still in active practice in their communities.



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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

SIMPLIFIED DIABETIC MANAGEMENT, By Joseph T. Beardwood, Jr., A.B., M.D., F.A.C.S. Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Physician to the Presbyterian Hospital in Philadelphia, and Herbert T. Kelly, M.D., F.A.C.S., Associate in Medicine, Graduate School of Medicine, University of Pennsylvania, Associate Physician, Presbyterian Hospital. Fourth edition. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944. Price $1.50.

Advances in insulin therapy, development of new forms of long-acting insulin, and food rationing in the war have made a new edition of this book necessary. Basically this book is for the patient, the diabetic, on the theory that with added knowledge he will be a better patient to handle. Also diabetes can now be treated in the home successfully. Theory and treatment are given as well as many tables of values to be used in arranging diet. A handy little book for both doctor and patient.

* * *

GLOBAL EPIDEMIOLOGY: A Geography of Diseases and Sanitation. By James Stevens Simmons, B.S., M.D., Ph.D., Dr. P.H., Sc.D., (Hon.), Brigadier General, U.S.A.: Chief Preventive Medicine Service, Office of the Surgeon General; Member National Research Council and Committee on Medical Research, O.S.R.D.; Tom F. Whayne, A.B., M.D., Lieut. Col. M.C., A.U.S., Formerly Director, Medical Intelligence Division, Preventive Medicine Service, Office of the Surgeon



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General; Gaylord West Anderson, A.B., M.D., Dr.P.H., Lieut.-Col., M.C., A.U.S., Director Medical Intelligence Division, Preventive Medicine Service, Office of the Surgeon General, Harold Maclachlan Horack, B.S., M.D., Major, M.C., A.U.S. Chief Dissemination Branch, Medical Intelligence Division, Preventive Medicine Service, Office of the Surgeon General, and Collaborators. Vol. One. Philadelphia-London-Montreal: J. B. Lippincott Company, 1944. Price $7.50.

The Global War has made the infectious diseases of the whole world of primal importance to all of us. Our soldiers are being exposed to all such infections and are then coming home to bring the infectoin to us, or not, as we are being told. But to understand and to be prepared we must know what the exposures are. This book is devoted to India and the Far East, and to the Pacific Area. Each country and the major islands is given especial treatment. The articles are arranged alphabetically, and cover geography and climate, public health, health services, water supply, sewage disposal, insects and animals, medical facilities and institutions, and diseases. These are well written articles, quite complete. At the end of each subject is a summary and a group of references. Maps are given in explanation, and a well-arranged index. This book will find its place in the libraries of all institutions of health and education.

* * *

SEGMENTAL NEURALGIA IN PAINFUL SYNDROMES. By Bernard Judovich, B.S., M.D., Instructor in Neurology, Graduate School of Medicine, University of Pennsylvania: Clinical Instructor in Neurology, Woman's Medical College; Chief of Neurologia Clinics, Philadelphia General Hospital, Graduate Hospital and Woman's Medical College Hospital, Philadelphia, and William Bates, B.S., M.D., F.A.C.S.,

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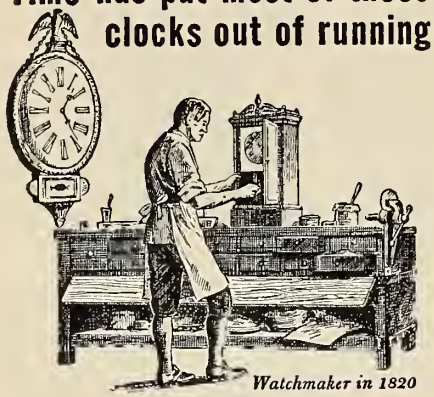
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F.I.C.S., Professor of Surgery, Graduate School of Medicine, University of Pennsylvania; Foreword by Joseph C. Yaskin, M.D., Professor of Neurology, Graduate School of Medicine, University of Pennsylvania. 178 Illustrations. Philadelphia: F. A. Davis Company, 1944.

The diagnosis and treatment of painful neuralgias is beautifully outlined and illustrated in this book. Much attention is given to the diagnosis and the location of tender areas in the skin in arriving at conclusions. The treatment by injection is carefully described and illustrated in detail, so that technique should be easy to follow. A very worth-while treatise.

* * *

THE ART OF ANESTHESIA, By Paluel J. Flagg, M.D., Visiting Anaesthetist to Manhattan Eye and Ear Hospital; Consulting Anaesthetist to St. Vincent's Hospital, New York; Consulting Anaesthetist to the Woman's Hospital, Jamica Hospital, Mount Vernon Hospital, Flushing Hospital, St. Mary's Hospital, Far Rockaway, New York, Nassau Hospital, Long Island, Chairman of the Committee on Asphyxia of the American Medical Association. Seventh edition. 166 Illustrations. Philadelphia-London-Montreal: J. B. Lippincott Company, 1944. Price $6.00.

The history of anesthesia, the agents used, the effects on the patient are given extensive attention. The physiology of anesthesia is studied. A chapter is given to the signs of anesthesia. Ether, ethyl chloride, chloroform, nitrous oxide, nitrous oxide-oxygen, nitrous oxide-oxygen-ether, and ethylene are all studied in detail with a thought to the teaching of good anesthesia. Local anesthesia and regional block anesthesia are detailed. The second part of the book is devoted to study of preliminary and postoperative medication, pre-anesthetic examination, the viewpoint of the patient, selection of



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methods and anesthetics, and many more topics important to the well-trained anesthetist. This book is a standard, well illustrated, printed in easily read type, and a good sample of the bookmaker's art.

* * *

CANCER: A MANUAL FOR PHYSICIANS. Published jointly by Michigan State Medical Society and Michigan Department of Health. Cloth. Pp. 225. Lansing, 1944.

This book is written by members of the Michigan State Medical Society under the editorship of its cancer committee. The Michigan Department of Health contributed toward the expenses of publication. Like that of similar books in other states, its purpose is to "assist the physician in making his diagnosis of early cancer and in reaching his decision as to the type of therapy to be employed, without subjecting the patient to the dangerous delay that sometimes occurs." There are forty-four unsigned articles by thirty-eight authors. These articles deal with the general and special aspects of cancer, including tumors of the brain and of bones. The articles are of course short but as a rule cover their topics well. The articles on biopsy in tumor diagnosis and on radiotherapy of cancer are especially praiseworthy. The statement about grading of cancer in the first of these articles merits quotation: "Many physicians attach far too much importance to the numerical grade of neoplasms. It must be kept in mind that the grade is assigned by the pathologist only in accordance with his impression of the level of differentiation. By itself, the grade tells nothing about



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the clinical state of the patient, nor does it indicate the prognosis. A grade 1 carcinoma may have been present for many years and may have spread widely by both infiltration and metastasis. It may still be grade 1 when the patient is about to die from its effects. Conversely, a grade 4 carcinoma may be so early and so small that the patient can be cured by a single sweep of a curet. Type of neoplasm, location, extent, duration and metastasis, as well as grade, determine the prognosis." It may be mentioned also that the fundamental principles of treatment remain the same whatever the grade. The article on carcinoma of the larynx is utterly inadequate, because it does not even mention its treatment with external radiation, which is now the treatment of choice of certain forms of laryngeal cancer. There are instructive articles on occupational cancer, on tumors of the endocrine glands, on the care of the patient with advanced cancer, on the Michigan program, on lay education and on cancer from the general practitioner's point of view. "The most worth-while service the general practitioner can render his patients who may have cancer is in prompt initiation of the processes through which they will obtain the best diagnostic and therapeutic services possible."—Review in J.A.M.A., Sept. 23, 1944.

* * *

DR. COLWELL'S DAILY LOG FOR PHYSICIANS. A Brief, Simple, Accurate Financial Record for the physician's desk. Champaign, Illinois: Colwell Publishing Company, Not Inc. 1945. Price $6.00.



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ECHOES OF THE 1944 WAR CONFERENCE

(Continued from Page 954)

M.D., who was taken ill with pneumonia a few days before the MSMS Annual Session.

* * *

Butterworth Hospital, Grand Rapids, sponsored a Scientific Exhibit on "Hip Fractures" at the 79th Annual Session of the Michigan State Medical Society in the Civic Auditorium, Grand Rapids, the week of September 25.

* * *

The Little Traverse Hospital of Petoskey sponsored a Scientilc Exhibit on the "Photometer."

* * *

ARTHUR M. HUME HONORED

As a testimonial to Arthur M. Hume, M.D., of Owosso, the oldest living Past President of the Michigan State Medical Society, the Shiawassee County Medical Society sponsored a banquet in Grand Rapids on the occasion of the MSMS Annual Session. All the living Past Presidents of the Michigan State Medical Society, as well as members of the Shiawassee County Medical Society, were invited.

Among the distinguished guests who honored Dr. Hume were: Herbert E. Randall, M.D., Flint (President 1927-28), J. D. Brook, M.D., Grandville (President 1929-30), Henry Cook, M. D., Flint (President 1937-38), Henry A. Luce, M.D., Detroit (President 1938-39), Paul R. Urmston, M.D., Bay City (President 1940-41).

Telegrams of congratulations to Dr. Hume were received from J. B. Jackson, M.D., Kalamazoo (President 1926-27), Louis J. Hirschman, M.D., Detroit (President 1928-29), J. Milton Robb, M.D., Detroit (President 1932-33), Col. Grover C. Penberthy, Omaha, Nebraska (President 1935-36), and H. H. Cummings, M.D., Ann Arbor (President 1942-43).

The welcome was given by C. L. Weston, M.D., of Owosso. The biography of Dr. Hume was read by A. L. Arnold, Sr., M.D., Owosso, the oldest member of the Shiawassee County Medical Society.

A book of congratulatory letters and other mementos of the occasion was presented to Dr. Hume.

R. C. Pochert, M.D., of Owosso, president of the Shiawassee County Medical Society, organized the meeting which was held in the Pantlind Hotel on September 27, 1944.



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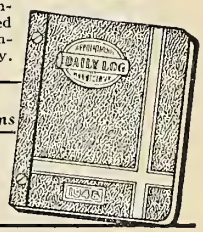


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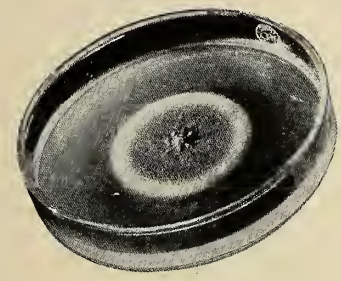
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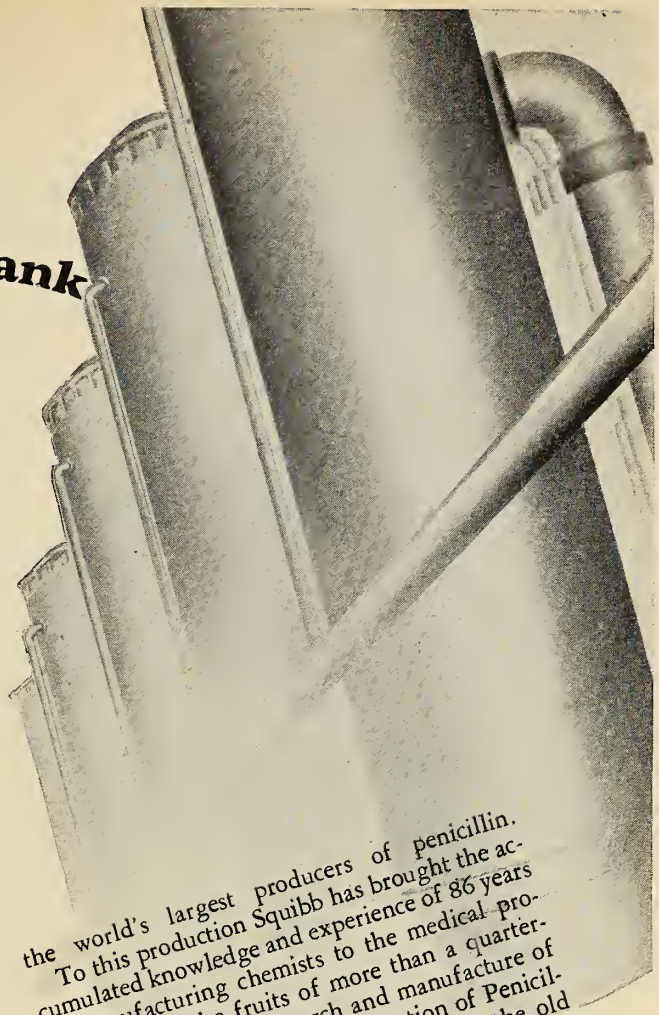
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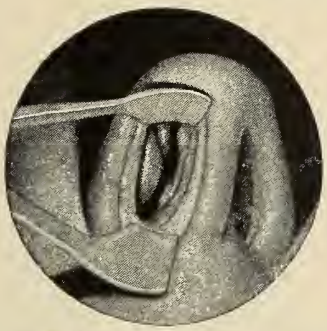


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WAR MEDICINE

ARMY ENDS ITS DOCTOR "DRAFT," NAVY'S GOES ON

Washington, D. C., Oct. 31—The War Department announced through the War Manpower Commission today that recruiting of civilian physicians for the army has been discontinued. WMC Chairman McNutt said, however, that recruiting for the Navy must continue because of an urgent need of approximately 3,000 more medical officers.

Other Agencies Seeking Doctors

The public health service of the federal security agency and the veterans' administration also are continuing to seek physicians.

McNutt disclosed he has been informed by the War Department that the Army will fill its future requirements for military physicians from sources now available, such as students and graduates of the Army specialized training program and a small number of individuals whose commissions are being processed. Accordingly, the Army no longer will require certification of availability of additional physicians from the WMC's procurement and assignment service.

McNutt reported that there are roughly 60,000 physicians in the Army, Navy, and the veterans' administration, a total representing about 40 per cent of the active medical profession in the United States.

"Grave Shortage" in Pacific

Vice Adm. Ross T. McIntire, chief of the Navy's bureau of medicine and surgery, informed McNutt that personnel expansion and intensification of Pacific operations have resulted in a "grave" shortage of medical officers.

With less than 13,000 medical officers in active duty in the Navy, the procurement of at least 3,000 more as soon as possible is imperative, Adm. McIntire said. Even this figure will not meet actual needs.—*Chicago Tribune Press Service.*

DOCTOR SHORTAGE PAYS OFF

In the past, when great battles were fought, loss of life was multiplied tenfold because of lack of prompt and adequate medical care for the wounded. But in the present war the story has been different. Even yet the full account of the achievements of medicine on "D-Day" has not been impressed upon the country.

One correspondent reports that within 45 minutes after the first troops landed on the shores of France, a medical unit was on the beachhead picking up casualties, while in the background a landing craft had been converted into an operating theater.

During the first day, twenty-two major operations were performed by this single unit. From dawn on "D-Day" until four o'clock in the afternoon, the unit remained on the beach. Blood plasma had been landed and transfusions made from mobile equipment.

Fifty thousand American doctors are in the armed forces. Every one of them is a trained expert at the business of saving lives. At least those civilians who had had to linger in crowded waiting rooms to secure the attention of the overworked doctors on the home front, can see the reason for the inconvenience thrust upon them—*Chickasha Star,* Sept. 21, 1944, quoted by the *Journal of the Oklahoma State Medical Association.*

PROGRESS IN CHEST SURGERY

Military surgeons are focusing attention on restoration of full lung function rather than the mere prevention of empyema in chest wounds—an important advance in thoracic surgery which is reflected in the surprisingly high number of chest cases returned to duty in the Italian campaign.

Out of 320 men admitted to one general hospital with penetrating chest wounds, 225 either returned to duty or were prevented from doing so by other injuries. Only fifty-four developed empyema. Of these, it was felt that five might require further surgery. And only two deaths in the group were directly attributable to chest wounds.

SEPARATIONS FROM MILITARY SERVICE

If any MSMS member knows of any Michigan physician in military service who has recently received an honorable discharge and is now back in this state, the State Society would appreciate receiving the name of the doctor so that he may be contacted and told of the opportunities available to him in connection with the medical Veterans' Readjustment Program, created by the MSMS House of Delegates at its 1944 session (see President's Page). Send names to the Readjustment Program Committee, 2020 Olds Tower, Lansing 8, Michigan.

IMPORTANT TO DOCTORS RETURNING FROM MEDICAL CORPS SERVICE

Doctors discharged from military service and returning to private (civilian) practice should give attention to the conversion of "Military Service" professional liability insurance policies to private or civilian practice coverage. Promptly notify your insuring company so that any adjustment indicated may be effected. "Military Service" policies do not cover professional liability in civilian practice (unless specific provision is made in individual contracts). Be on the safe side and convert at once to private practice coverage.

Table of Contents

Neuropsychiatry and the General Practitioner.
Col. William C. Menninger, MC.....1069

The Gastroscope as an Aid to Diagnosis.
A. Ray Hufford, M.D......1076

The Surgical Treatment of Gall-bladder Disease.
Max M. Zinninger, M.D......1082

President's Page:
Our Medical Veterans' Readjustment Program..1089

Editorial:
"Michigan's Medical Plan Sets Pace for the Nation" 1090
Government Medicine Again.....1090
The Michigan Public Opinion Survey 1091
Political Medicine 1092

Michigan State Medical Society:
Proceedings, Seventy-ninth Annual Session.....1093

You and Your Business.....1103

In Memoriam 1104

Woman's Auxiliary 1108

County and Personal Activities.....1113

County Secretaries' Conference.....1120

The Doctor's Library.....1121

War Medicine 1040

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HACK'S FOOT NOTES

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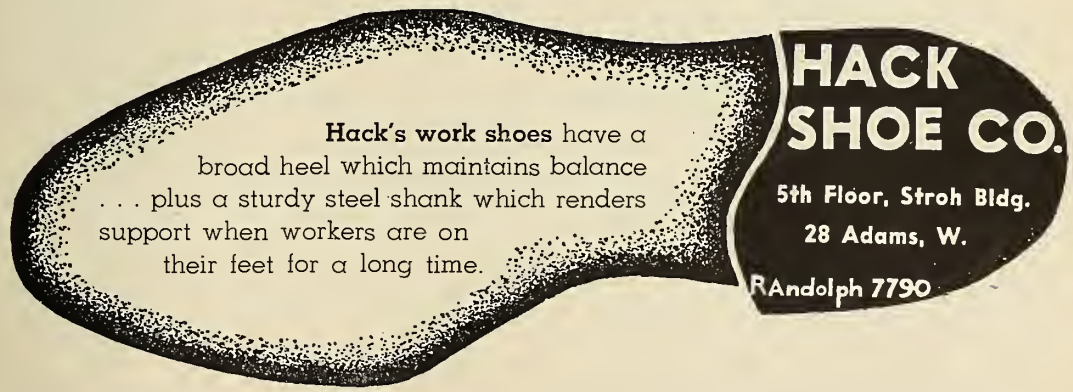
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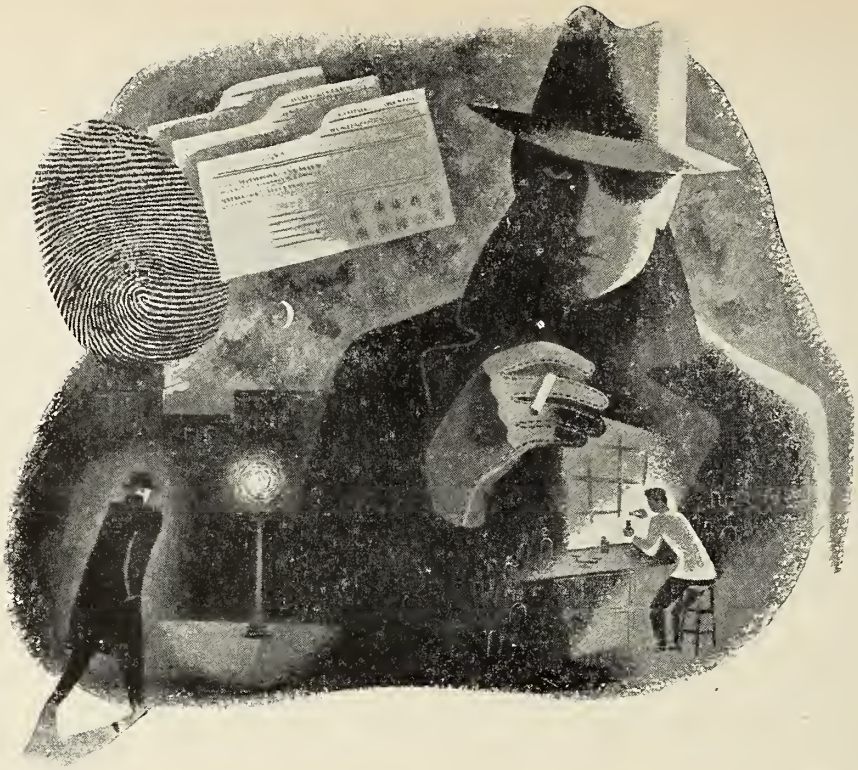
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The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

Volume 43 December, 1944 Number 12

Neuropsychiatry and the General Practitioner

By Col. William C. Menninger, MC

Washington, D. C.



Director of the Division of Neuropsychiatry, Office of the Surgeon General, Army Service Forces, Washington, D. C.

In the army, if a man cannot function as a full-duty soldier, he of necessity must go to the hospital. As a result, the medical officer sees many types of illness much earlier than in civilian life. Some of these are emotional difficulties and every medical officer has become aware of the fluidity of the soma and the psyche in the production of symptoms: gastric, cardiac, orthopedic, and in every body system. The problems arising concern themselves with the understanding of this type of symptomatology: what is the significance of such symptoms? What is the best approach to elucidation and understanding of them? What are the most effective treatment measures for such? The author attempts to answer these questions.

■ Just as the little World War of 1917-1918 served as an impetus to the development of great strides in the field of medicine, the present World War has produced numerous brilliant advances and achievements. Medicine has always held a unique place in war, being a constructive process in a wholesale destructive effort. There are many factors which make possible the advances that medicine can effect in this situation: it performs in a co-operative fashion and in a uniform and regulated manner as an integral part of a tremendously large machine and, by so doing, can more likely direct its aims in a specified and comprehensive method. Of necessity, the field of preventive medicine must insure the functional capacity of great masses of people, and all efforts can be directed in a fairly well regulated channel in contrast to the dependency on voluntary co-operation of much smaller groups in civilian life. Thus, the new louse powder, DDT, can be effectively and promptly used not on thousands, but literally on millions, of individuals.

Similarly, in clinical medicine, the efficacy of particular drugs or methods tried out in great masses, with the results quickly to be established. All the help of many civilian investigators, clinicians, and laboratories, as well as all of the clinical resources of the Army, can be directed at a focal point with a high degree of efficiency. Thus, the utilization of the sulfa drugs reduced the death rate in meningitis from a figure of 38 per cent in the last war to 4 per cent in this war. With the size of the present Army, this means literally the saving of thousands of lives, plus the indirect benefit to results of such work for civilian health. The pneumonia death rate similarly has been reduced from 28 per cent to 0.7 per cent. The fatality rate of tuberculosis has nearly been eliminated, having been reduced from 7.3 per cent in the last war to 1.8 per cent in this war. It was possible to quickly determine the effectiveness of the prophylactic use of sulpha drugs in the prevention of meningitis by its regulated usage in large numbers of individuals in a relatively short time.

Tremendous advantages have been made in surgery with the use of the sulfa drug, the very wide extension of the use of whole blood, particularly blood plasma in shock, and the develop-

Read at the Fourth Annual Conference on War Medicine, the Seventy-ninth Annual Session of the Michigan State Medical Society at Grand Rapids, Michigan, September 29, 1944.

ment of penicillin, the wonder drug. These, plus the improvements in our methods, have resulted in a reduction of the mortality rate from battle wounds from 8.1 per cent in the last war to 3.5 per cent in this war. It is not surprising to discover these results when we consider that some fifty thousand physicians are devoting their full time to some eleven million men, under circumstances which necessitate the maintenance, as nearly as possible, of the ideal health for the individual.

All the specialized fields of medicine have made advances. Considerable progress has been made in neuropsychiatry, not so much in specific new information that has been sifted and proven, to date, as in its advance through virtue of its wider recognition. In other words, the gain is not measured altogether by what neuropsychiatry has discovered but, rather, by what people in general have discovered about neuropsychiatry. The war has given us an opportunity, a necessity, to examine more than twelve million men, and the responsibility to determine whether they can make the readjustment required to serve in the military forces. We have attempted to help those accepted to make this readjustment, cognizant of the tremendous difference that exists between the way of life of an average American civilian and the nearly antithetical changes required in the Army. Giving up his freedom of action and accepting the strenuous demands of the Army does require a major readjustment and it has been found that many men cannot make this adjustment. The war has forced upon us the necessity to fortify a man to meet battle, to be willing to sacrifice his life, to function under conditions which are beyond the comprehension of anyone who has not experienced them. One of our spectacular discoveries has been the recognition that any man, the strongest of personalities, if subjected to sufficiently severe strain over an indefinite period, may be unable to function. And, finally, we are faced with the necessity to attempt to rehabilitate those men who have evidenced their maladjustment. The war has demonstrated in a dramatic fashion the part emotional factors may play in an individual's motivation to do a job, in the expression of his maladjustment, in the development of physical symptoms, and in the causation of chronic illness.

Among those who have come to have a new appreciation of these facts are the physicians themselves, especially younger men now serving with the armed forces. An even greater challenge and responsibility of the medical profession is to disseminate these findings to the public, in so far as people can be helped by their assimilation and by their understanding. The casualties are returning to civilian life now and will continue to return. It is our opportunity and our responsibility, not only to help these men in their readjustment to civilian life, but to assist their families, their friends, and their communities in the understanding of these casualties.

For reasons of national security until the war is finished, figures cannot be given to indicate the numerical extent of the neuropsychiatric problems in the Army. We do not have the answer to all the problems, although definite strides have been made in the direction of the solution of many of them. The experience has given us several points of specific application of neuropsychiatry to the fields of internal medicine, surgery, and, in some degree, to other specialties. However, before attempting to point these out and in order to give some background for their understanding, it may be pertinent to enumerate the highlights of the neuropsychiatric experience we have had, to date, in the present Army.

Screening

The major lesson learned in the last war and repeated again in this, is the fact that screening serves only the purpose of eliminating grossly abnormal men. It cannot eliminate a large number of individuals who may have made a border-line life adjustment, nor can it possibly eliminate a large number of "normal" men who, under the prolonged stress of environmental and battle conditions, develop maladjustment. The methods used in our induction centers for neurospychiatric screening, now being continuously improved, have not been entirely adequate because of various factors:

1. In a speedy formation of a large Army, we have had to examine rapidly.
2. We have had an inadequate number of qualified nueropsychiatrists. Of roughly 150,000 physicians in this country, there are 3,000 neuropsychiatrists, of which roughly, in turn, thirty per cent are in the armed forces.
3. Until the last few months, we had no system of providing historical data about men examined; con-

sequently, the examiner had to rely entirely upon impressions and verbal communications from the man, obtained in an extremely short contact. With the development of the Medical Survey Program, which is still only getting under way, this further feature will materially help in screening.

Of all the rejections for medical reasons, the neuropsychiatric rejections have accounted for as much as forty per cent during a given month. Considerable concern has been expressed by uninformed individuals over the discovery of such a large incidence of apparent psychopathology and various explanations have been offered, including an indictment of the examination methods in general and the neuropsychiatrists in particular. It has been no surprise to neuropsychiatrists that this segment of the population has been uncovered and it is no special cause for alarm as to the mental health of the nation. This finding does have an important sociological significance, which should not be ignored, and has ramifications into our democratic method of living, our determination to be individualists, and our resentment of authority. It concerns our family life and our educational system. It is intimately linked with the prevailing attitude of the public toward specific service in the Army. To many men, the security of their home, friends, and their job far outweighs their belief in their importance for and their need by the armed forces. The rejection of this group of men for acceptance into the Army has been widely misinterpreted and misunderstood. Too many individuals have regarded the Army as a combination social agency for rehabilitation of bad boys and puny specimens. The Army, like a football team, needs the best and, while every effort has been made and is being made to utilize manpower within the Army, it cannot accept individuals obviously and grossly pathological. The fact that a man may be a regular worker, a community asset, is no indication that he can fit into the Army or be an asset to the Army. Many men can hold a civilian job with efficiency, who would be unable to fit into the regimentation and the discipline of the Army.

Prevention

Once a man is taken into the Army, a major effort is made to help him become an effective soldier. It is recognized fully that the necessary readjustment from civilian life of ease, comfort, and free will, to the Army life of discipline, regimentation, and strenuous existence is a very great one. Recognizing the importance of the neuropsychiatric implications when a man fails to make this adjustment, the Surgeon General has taken steps to place neuropsychiatrists in strategic units of the Army so that they may provide a program of prevention as well as immediate and early consultation with individuals failing to adjust. In every training center, both in the Army Ground Forces and in the Army Service Forces, a mental hygiene consultation service is in operation. The neuropsychiatrists in these centers not only see soldiers in the early stage of maladjustment but, far more important, they present mental hygiene lectures to officers and to enlisted men in training. These lectures were authorized in order that the officers might be more cognizant of the beginning signs of maladjustment in their men, individually and as a group, as well as their own responsibility as a unit commander for the maintenance of morale and mental health. Similarly, in every division, a neuropsychiatrist has been attached to the surgeon's office to carry on essentially the same functions as the neuropsychiatrist in the training center, plus the additional responsibility of treating neuropsychiatric combat casualties. In every large post, the neuropsychiatric section of the station hospital maintains an outpatient clinic, through which, in many instances, it is possible to keep men on duty through psychotherapeutic help provided in one, two, or three interviews with men referred.

Orientation

In addition to specific orientation for officers and trainees relative to mental health, mentioned above, the Army has taken major steps to meet the need to orient men as to their role in the Army. This need is inseparably linked with the even larger field of motivation as to "why we fight." Why should a man be willing to have himself wounded or very possibly killed? Through the Morale Services, orientation officers are placed at various strategic levels: in each post and camp, in each training center, and in each division. It is the aim of this group to provide information on "why we fight" and to orient the soldier as to his role. There is a direct relationship between the state of motivation

and the number of neuropsychiatric casualties. When a man feels that he is not important, that his job is not important, and, as occurs in the Army, when this job is difficult and strenuous, he makes little conscious effort to hold his natural unconscious defeatism in check; consequently, it is essential that every soldier be sold on his own importance, the importance of his job, and the reasons why we must win the war.

Treatment

Despite our best efforts at screening and our best efforts at prevention and orientation, a considerable number of men *do* break down psychologically. Regardless of what we call them diagnostically or the reasons for their breakdown, they do not make good soldiers. It does not help for the officer or the civilian public to become incensed about the frequency with which such difficulties occur, since their emotion does not change the man's personality or his capability to be a soldier. This the Army must decide. The Army, and, more specifically, the Medical Department, assumes the attitude that the man who fails in his initial adjustment is salvageable until proved otherwise. On this basis, immediate treatment is provided in every possible facility. Thus, in combat it has been possible to return from thirty per cent to 50 per cent of neuropsychiatric casualties and, in some areas an even higher percentage than this, back to combat duty. An additional 20 per cent or 30 per cent are salvaged for further duty in the line of communications or the zone of the interior. Within the zone of the interior, psychoneurotic patients were originally hospitalized. Recently steps have been taken to treat this group on a more realistic and practical basis by placing them in uniform in reconditioning units attached to hospitals rather than being ward patients in the hospitals. Gradually more efficient methods of reclassification of these men as to the best type of job assignment are being accomplished, with subsequent reassignment.

Specific Factors Increasing Neuropsychiatric Disability

As has been mentioned above, the motivation of a man becoming a soldier is a very important feature in facilitating his adjustment. The Army has spent, and is spending, much thought and effort in the development of adequate orientation material for our soldiers. From the low level of an Infantry private, we have to recognize that he can see that Russia has been overrun and that their people are anxious to vindicate themselves and reclaim their land. He knows that England has been bombed again and again and that the civilian death rate resulting directly from the war has been of no small figure. He knows that China has been overrun; he knows that Australia has been dangerously threatened. Furthermore, he receives letters and newspapers from home, and he knows what is going on here just as well as we do. If we add up these facts, i.e., his picture, and contrast the hell that confronts him —battle—we may gain a glimpse of the problem of orientation, as well as a factor in the causation of neuropsychiatric battle casualties.

One should not pass over too quickly the plea that we attempt to see his picture, if for no other reason than to grasp a concept of the stress placed on the personality. No one can portray, no one can understand, the hell that that man faces: the constant threat to life; the repeated vision of death, of the maimed, of the wounded; the physical discomforts; the lack of sleep. No one can vaguely portray the emotional stress of even one night in a deep jungle with intense heat, mosquitoes, the screaming of bats and birds, the creeping of animals, with every second filled with the knowledge that there are Jap snipers on all sides.

Then there are other factors operating in the Army which affect the apparent rate of neuropsychiatric casualties. One of the more important of these is the fact that in civilian life if a man develops a headache, if he becomes somewhat emotionally upset, he can take the afternoon off or, if necessary, the week end, or can even go for a vacation. He may never go to a doctor; in fact, he likely does not. On the contrary, in the Army one is either on full duty or he is in the hospital. In civilian life if you wanted to take alka-seltzer or a bromide, it was your free choice. In the Army we have tried to provide men with some sulfa drug but there is no way that we can cater to his individual eccentricities.

On the other hand, it is often not understood that the Army has made very strenuous efforts to utilize men with certain handicaps. The manpower shortage has been such that this is a necessity. The public may fail to recognize that

a very large number of men, some with physical handicaps, some with psychological limitations, are being widely used. In a recent experiment, seventy per cent of the men from three different, specially-created battalions composed of psychoneurotic patients taken from our hospitals were returned to duty. The reconditioning units of our hospitals return many men not only to limited duty but large numbers to full combat duty.

Lessons Applicable to Civilian Practice

From the above vast experience, even at this comparatively early stage in our evaluation of it, certain points stand out as having special significance and definite implications in the civilian practice of medicine.

1. *Co-operative practice.*—One of the greatest compensations in the practice of medicine in the Army is the intimate association between the various specialties and the close co-operation that exists between the men within these specialties. Particularly is this true of neuropsychiatry. Throughout the military forces doctors work in groups and only with very few exceptions are they alone. More accurately, one may say they work in teams: hospital teams, dispensary teams, or regimental or divisional teams, which afford an intimate shoulder-to-shoulder relationship between the surgeon, the internist, the neuropsychiatrist, and all other specialties. Undoubtedly, one of the most important after-effects of the teamwork will be the better understanding among the members of this team—understanding of *each other* and understanding of the *work* in their respective fields. There is no doubt but that the neuropsychiatrist is learning much about medicine and surgery; likewise, the military situation is requiring that the internist and surgeon learn much about neuropsychiatry. We have no qualms in calling consultations; we are not afraid of losing our patients. We are interested in supporting our confreres. With fifty thousand physicians accustomed to and enjoying this opportunity and utilizing this method of group help over a period of two, three, or four years, it can be anticipated that there will be major repercussions in our subsequent civilian practice. It will be the wise civilian physician who, reading the handwriting on the wall, adjusts himself to this method and perhaps even modifies his own practice accordingly.

2. *Soma-psyche fluidity.*—As mentioned above, the circumstances under which medicine is practiced in the Army bring the patient to the physician much earlier than he may have appeared in civilian life. Furthermore, many patients come to the Army physician who would not come to the physician in civilian life. Again, I may state that in the Army a man is either on full duty or else he reports to the dispensary or the hospital, regardless of whether his complaint be anxiety or flat feet, a headache or a fever. It may be that our system of medical education focused our attention so intensely on the anatomical, on the physiological, and on the chemical, that many of us left medical school totally unequipped to evaluate the person that lives in the body. Furthermore, we were so influenced by laboratory findings and x-rays that, for many men, these became more important than their own clinical examinations. As a result, too often patients with functional complaints receive no satisfaction from one physician and keep shopping from another to another. In the Army there is no alternative. The patient has no choice and the physician has ready access to a series of specialists. In every Army installation there is the complete team available for the total examination of a patient and this includes the neuropsychiatrist. When the neuropsychiatrist is competent and helpful, he has more consultations than any other officer in the hospital.

The immediate result is an increased awareness, on the part of all medical officers, of what I choose to term the fluidity between the psyche and the soma. A man's difficulty may be homesickness expressed in terms of gastric distress. It may be anxiety expressed in terms of cardiac irregularity or palpitation. It may be resentment expressed in terms of a low back pain or distress centered around an operative scar. Every medical officer is having the experience of seeing the various and devious ways in which the personality uses the different systems and organs of his body to express his emotions. The alert physician is cognizant of the fact that in the great, great majority of these instances the man is sick, not as he says, but with a definite psychological illness.

We medical officers are seeing many more instances where patients unconsciously exaggerate complaints of illness as the result of anxiety or

fear, and such behavior is usually a manifestation of a psychoneurosis. This type of reaction is not to be confused with malingering, the conscious and deliberate feigning of an illness to escape duty. The essential characteristic of every psychoneurosis is that it represents an unconscious resolution of conflicts and therefore, serves a purpose. The manifestations are as far beyond conscious manipulation as is blushing. Unfortunately, this distinction between unconscious and conscious is often difficult to distinguish. Not infrequently the unconscious mechanism is not recognized and is mistaken by the medical officer as a conscious evasion. To castigate such a patient as a goldbrick is not only scientifically inaccurate but is prejudicial to the man's welfare. The restoration of the patient demands, in the first place, an understanding by the medical officer of the painful situations which cause the soldier's emotional conflict; in the second place, the interpretation of this knowledge to the patient in skillful and understandable terms is a necessity. Understanding the nature of the emotional mechanism by the physician frequently provides the key to therapy and, instead of creating the confirmed invalidism of a chronic psychoneurotic, it frequently transforms an ineffective patient into an efficient soldier. These facts have implications just as truely and just as widely in civilian practice as in the Army practice and the purpose in mentioning it here is to point out again that every medical officer is becoming increasingly aware of the fluidity between the emotions and the bodily systems, the psyche and the soma.

3. *The types of psychosomatic responses.*—Much might be said regarding the wide variety of neuropsychiatric symptomatology observed in the Army hospital. A few comments on certain of these are pertinent for every physician. It is no surprise, under the circumstances in which we practice in the Army, to find that every cardiovascular ward of an Army hospital contains a considerable number of individuals with functional cardiac disturbances. An equally high percentage of functional disturbances are found on the gastro-intestinal ward and there is no small percentage of the same type of individual on the orthopedic wards. In fact, every ward, with the exception perhaps of the acute infectious illnesses, presents a considerable number of these individuals.

Our battle experiences are providing us an opportunity to see a large number of strictly neuropsychiatric cases but, nonetheless, expressed in physical symptoms. There is a large group of individuals in whom the most conspicuous symptom is known as the "startle" reaction. In these there is a motor excitation on the occasion of every noise, particularly if that noise can be associated with battle experience. The patient manifests the reaction by "jumpiness" and exhibts extreme anxiety and fear through the stimulus of any type of noise. Thus, it is recognized that individuals with this type of reaction may have difficulty in going into a subway many months after their battle exposure; they are distressed every time an airplane goes overhead. Another rather large group of individuals can best be described as those having the "shakes." They present a gross tremor of practically the entire body, uncontrollable and intensified with very minor stimuli. Still another psychomotor group are those which present spontaneous tearfulness, acute anxiety, and restlessness. It should be pointed out that every physician connected with combat experience will have had occasion to see many of these types of patients, all of whom, whether they be on the cardiovascular ward or manifest a "startle" reaction, are to be recognized as personality disturbances, as neuropsychiatric problems.

4. *Management of the neuropsychiatric aspects of general cases.*—Certain generalities can be made about the management of the neuropsychiatric aspects of all general medical and surgical cases, particularly the so-called psychosomatic group; i.e., those patients who express their emotions through physical symptoms. This question is perhaps most directly approached by pointing out our common mistakes. These mistakes are made by every physician, in a frequency, depending upon the degree of his understanding and his insight into this type of problem and, on the basis of Army experience, are particularly applicable to our civilian practice.

All too often, the physician fails to take into account the environmental situation in which the man is functioning. Thus, in the Army we recognize there are various specific stresses and, to

fully understand the patient's response, we must carefully scrutinize the stresses of the particular environment. All too often it is assumed that the individual with functional complaints is a "weakling." In this assumption we fail to recognize that he may not be a "weakling" in any sense but the situation may be an extremely difficult one. We have learned in the Army that every man has a potential breaking point and that the integration of his personality may break down when the stress is sufficiently great over a sufficiently long period of time. In other words, we must recognize that many neuropsychiatric casualties, both in the Army as well as in civilian life, may result because the situation is so tough.

A second common error is the assumption that a man's total clinical picture of illness is *either* physical *or* psychological. This either/or concept is totally inaccurate and must be supplanted with an attempt to evaluate how much of the difficulty is physical and how much of it is emotional. It is unquestioned that there will be an element of each in every type of illness, whether it is a psychosis or a broken femur. Obviously, only on the correct evaluation of these factors can appropriate and adequate treatment be given. It is equally erroneous but entirely comparable to treat a case of neurocirculatory asthenia with digitalis as it is to provide only psychotherapy for a cardiac decompensation. All too often the physician assumes that in the absence of physical findings no therapy is necessary or, if the findings indicate only a functional difficulty, that he can pass off the patient with the platitude that nothing is the matter with him. All too often, the physician deludes himself that he is practicing scientific medicine when he hands out some platitudes or placebos.

A third common mistake is our tendency to over-examine the patient and, in too many instances, to over-hospitalize him. Much too frequently the patient is given everything in the gamut of the examinational procedure with the result that he has very good evidence to believe that his case is either very mysterious or else the doctor is a fool. We recognize that the average type of functional disorder, whether it be heart, stomach, or any other organ, unless actually incapacitated, should not be hospitalized further than any necessary investigative procedure necessitates. The physician fails to recognize that this over-examination and over-hospitalization are interpreted by the patient as indicating the serious nature of his difficulty and may very well result in the patient's being all too prone to focus his attention on the physical aspects of his illness rather than the emotional aspects and the necessity to readjust himself to his environmental situation.

An additional common error is the tendency of over-emphasizing a particular finding in an individual case. Often in an attempt to be helpful, the physician may point out that the heart is a little rapid, that there is a trace of albumin, or that there is a quarter of an inch shortening. Every personality is suggestible, some much more than others, and always when a patient comes to a physician he has a lurking concern in his heart of some ominous threat to his well-being. When the physician inadvisedly stresses a particular minor physical finding as if it were important, this, in a sense gives the patient a hook on which he may hang his anxiety. Unintentionally we physicians crystallize and substantiate the patient's misconception of his illness.

Another lesson we have learned in the Army is the tendency of most physicians to underevaluate the necessity for the reconditioning of a patient. The fact that he is able to leave the hospital does not indicate that he is well, nor does it suffice to have him return to the physician's office occasionally for a check up. Psychological factors in reconditioning are grossly ignored. The recovery of every individual from every type of illness is very possibly determined more by his psychological attitude than by any other factor. Through some sort of curious scotoma, the consideration of this factor has been conspicuously absent in most studies of the process of getting well. Because it happens regularly, we assume that the operation will heal, the pneumonia will resolve, the decompensated heart will readjust. We have vaguely been aware of the fact that the recovery of gastric ulcer does have a more direct and obvious relationship to the patient's emotional life. As a whole, we have ignored the emotional life in our general medical and surgical patients both before and after our specific treatment. For practical reasons, in some cases study of the emotional factors before emergency medical or surgical treatment is not so important. After such treatment it should be essential. A lesson learned in the Army is the importance of conscious motivation of the aim to be accom-

plished and our knowledge of unconscious motivation make it obvious that such an evaluation should be made in every convalescent patient. The physician who fails to do so is an offender against his patient, as well as against the best practice of medicine.

Finally, one of our most serious and far-reaching errors is our widespread failure to recognize the psychological factor in all illness, to recognize the struggles of the person who lives in the body, to accept literally the advice to treat the whole person. In the Army the patient has no choice but in civilian life this scotoma of the medical profession is the chief reason for the thriving state of countless quacks and charlatans. Many physicians almost pride themselves on their ignorance of neuropsychiatry. Most of us learned little in medical school that aided us in evaluating the psychological factors in our patients' illnesses. But we must recognize that our loves and our hates, our successes and failures, our joys and our disappointments, are the most potent factors in determining our total state of health. If we acknowledge this, even in our advanced knowledge of bacteria and bullets, we as a profession cannot progress using the tactics of the ostrich toward the contributions of the emotions in the causation and recovery in every type of human ill.

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FORUM ON ALLERGY

The seventh annual forum on allergy will be held in the Hotel William Penn, Pittsburgh, Pennsylvania, on Saturday and Sunday, January 20-21, 1945. This is a meeting to which all reputable physicians are most welcome, and where they are offered an opportunity to bring themselves up to date in this rapidly advancing branch of medicine by two days of intensive postgraduate instruction. For instance, the twelve study groups, any two of which are open to him, are so divided that those dealing with ophthalmology and otolaryngology, pediatrics, internal medicine, dermatology and allergy run consecutively. In addition, the study groups are arranged on the basis of previous registration. In this way, as soon as the registrations are completed, the registrant is expected to write the group leader and tell him just what questions he wants brought up in the discussion. Attention is also called to the fact that during these two days almost every type of instructional method is employed. Special lectures by outstanding authorities, study groups, pictures, demonstrations, symposia and panel discussions.

The Gastroscope as an Aid to Diagnosis

By A. Ray Hufford, M.D.

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Improvements in the gastroscope and the availability of this for diagnosis in last few years has brought about rapid development of this diagnostic procedure which is indicated in all patients with chronic or recurring gastric distress where the x-ray diagnosis is negative or indeterminate or as a check on all ulcers and all malignances to determine operability.

Gastritis which is quite commonly present in patients with gastric complaints can only be definitely diagnosed gastroscopically. The close coöperation between the roentgenologist and gastroscopist is necessary to give the highest percentage of accurate diagnosis.

■ Although the history of the use of the gastroscope in the diagnosis of gastric diseases is extremely interesting and unusual, it will only be recounted here briefly since it has been so adequately summarized by Schindler.[11] It is interesting to note the first earnest attempt at gastroscopy though unsuccessful, was made by Kussmaul in 1868, and later by Mikulicz and Leiter in 1881. Kelling and also Kuttner in 1897 constructed crude instruments to a degree flexible, yet still impractical. In 1907 Chevalier Jackson was trying to develop gastroscopy from esophagoscopy using simple open tubes and in 1908 Loening and Stieda worked out a partially flexible gastroscope with an inner rigid optical tube which slid down into the flexible part once it was *in situ*.

In 1911 Sussmann made a flexible type instrument with an improved optical system. However, it was not until 1932 after several years work in the study of these previous gastroscopes that G. Wolf was able to work out with Rudolf Schindler the flexible gastroscope as it is known today, by using a series of short focusing lenses in a flexible rubber covered shaft, and which enabled them to see the interior of the stomach better than ever before and in a safe manner.

Improvements in the German gastroscope was made after Schindler came to America with the aid of Cameron, who has produced this instrument in this country since 1939. The instrument was strengthened considerably. This was done by substituting for the phosphor bronze spiral, one of stainless steel. This steel spiral is just as flexible but never kinks and keeps the lens system in a perfect coördinated balance. As there are forty-seven elements in the optical system, it is very necessary to have this well protected and in perfect alignment as well as free from soiling. The position of the handle which houses the switch was placed on the same side of the scope as the objective and affords better handling of the gastroscope when working in the lower depths of the stomach.

Taylor[14] described a new type gastroscope in 1941 with a controlled flexibility of the distal part after the scope was *in situ,* by manipulation of a series of wires from a control at the head of the instrument. This type scope presented some mechanical difficulties which has prevented its wide spread use in this country.

The Hardt-Eder[6] Gastroscope, just recently developed and first shown at the Scientific Exhibit of the American Medical Association for 1944 at Chicago, Illinois, is reported by the inventors to have many advantages over previous type instruments. It especially gives a clear picture with a good sized field of vision of about seventy-five degrees, which is mechanically adjustable. It has a semi-flexible outer sheath with a small rigic optical tube, which contains twenty-four lenses that passes down through the outer flexible tube once the *Scope* is inserted and gives more definition and a third dimension.

That gastroscopy was slow to gain favor, particularly in this country prior to 1939 may be attributed to several factors. First, it was a new instrument and had to overcome skepticism as to its safety and value, as relatively only a few had knowledge of its technique and proper training in order to make a satisfactory examination. Availability and safety of such a procedure by competent examiners was therefore one of the first prerequisites. However, in the last five years great strides have been made by training of competent clinicians to use the gastroscope, and today, it is a recognized diagnostic procedure, and the services of a well-trained gastroscopist is demanded in any large progressive civilian hospital or clinic as well as in the various military hospitals.

X-rays, as important as they are in the diagnosis of intragastric pathology, coupled with complete clinical examinations and routine laboratory tests still leaves much in doubt in many cases. If one is to detect early malignancy before too extensive spread of the disease, or to diagnose the various types of gastritis as well as small ulcers and polyps, the diagnosis must be made in the vast majority of casts by the gastroscope.

A high threshold of suspicion must exist in the physician's mind in order to bring about the proper application of various modes of examination in order to detect some diseases of the stomach before they have done irreparable damage. Much too often is the feeling on the part of the busy practitioner that when he is confronted by a patient complaining of some vague upper abdominal pain, to feel that when he has procured an x-ray of the gastro-intestinal tract and the gall bladder, that he has done enough and much too often is satisfied with the reports given him without further questioning. Often lack of interest is shown if the roentgenographic reports are negative, and the patient is endangered by being treated as a neurotic or on the basis of hyperacidity.

As in other fields of medicine, pronounced pathologic disturbances of the stomach are often easy to recognize. It is the milder and less obvious pathological disturbances which tax the ingenuity and resourcefulness of the physician.

Many times although the pathologic alterations are not great, the functional derangements may be most severe and distressing to the patient, and very annoying to the attending physician. Nervousness in different manifestations are apt to be the chief complaints, and endanger the patient with the diagnosis of nervous indigestion. It is therefore of utmost importance not to assume, but to give the benefit of doubt to any patient with gastric distress which persists or recurs.

There is little wonder, when we stop to consider, that the gastric mucosa would not suffer greatly with all the frequent upsets in childhood from indiscrete diets and acute diseases, and also later in life when the mucosa of the stomach is subject to repeated insults from irritating foods, excess condiments, lack of vitamins, excess cof-

fee and alcohol, not to mention the various types of infection and nervous strain.

In patients suffering with digestive disturbance when examined gastroscopically, there are findings of diffuse alteration in the mucosa in forty per cent of the cases. It is of interest to note such gross changes in the gastric mucosa as observed and reported so beautifully by Beaumont on his servant, Alexis St. Martin, where he could directly observe daily through a gastric fistula these changes in the mucosa. These findings, disregarded for a hundred years, are now rediscovered at the gastroscopic examination.

These various reactionary conditions in the gastric mucosa are classified generally under the heading of chronic gastritis. Schindler[9] lists several forms of gastritis, the most important of which are acute and chronic superficial gastritis, atrophic gastritis, and hypertrophic gastritis.

Acute and chronic superficial gastritis have no specific etiological factor, but likely arise from acute illness, chronic foci of infection, vitamin deficiency, and in some chronic debilitating conditions. Later these may change to atrophic gastritis.

When the superficial gastritis changes to atrophy, the clinical picture changes. The gastric symptoms become less marked and the general symptoms come into the foreground of the clinical picture. Weakness and nervousness come in spells, and there is danger that such patients may be treated as a psychoneurotic. Epigastric discomfort and fullness after meals, anorexia, and sometimes nausea, especially if this is accompanied by a sore tongue and paresthesias, is highly suggestive of atrophic gastritis and its concomitant systemic disturbance, and should be treated with large doses of liver and vitamin "B" as well as other measures to improve the general health.

Chronic atrophic gastritis is a very serious disease in as much as it may be a forerunner of pernicious anemia or gastric carcinoma. About one third have anacidity and the remainder as a rule have sub-acidity or normal acidity. It is seen almost constantly in pernicious anemia, and very commonly in pellagra, sprue, and in vitamin deficiency in general. The atrophy may be patchy, localized or diffuse, or complete. When marked, the atrophic areas show a thin, mottled grayish or green gray color and thinning of the rugal folds. Blood vessels are seen through the thin semi-transparent mucosa. Atrophic gastritis may develop within a few months, and then it may remain stationary unless treated. Schindler and Serby[12] suggested that atrophy of the gastric mucosa might be due to a deficiency state. They observed the disappearance of gastroscopic changes of atrophic gastritis in patients with pernicious anemia following adequate liver therapy, and the same has been reported by other observers.

Patients suffering with atrophic gastritis have three times the chance of developing a gastric carcinoma than other healthy adults, therefore, it is our obvious duty to diagnose this disease as early as possible, and to watch these patients closely by frequent x-ray and gastroscopic examinations.

Chronic hypertrophic gastritis is frequent and sometimes very severe. The symptoms are chiefly gastric, and highly suggestive of ulcer. Night pains and delayed pains are frequent. In some cases x-ray examination gives the picture of the so-called cob-corn or granulation relief picture, but usually the x-ray is normal and the sovereign diagnostic method is by aid of the gastroscope. The pathological changes are chiefly located in the body of the stomach, rarely in the antrum, and they may be diffuse or circumscript. The gastric mucosa looks swollen, velvety, dull, and the highlights are reduced, nodules and verrucoe are seen. The folds sometimes look segmented. Not infrequently superficial ulceration are observed. These superficial inflammatory ulcerations never appear to develop into true chronic gastric ulcers. Mucosal hemorrhages are often present. Benign gastric ulcers may be single or multiple and may be situated in any part of the stomach. Acute are more common than chronic and more likely to be multiple, but duration usually brief, therefore, less likely to be detected clinically.

Subacute, and chronic ulcer, usually occur singly and most often situated in the region of the lesser curvature. Occasionally of large size, the superficial flat ones tend to bleed, and small funnelshaped ones, to perforate.

It is no longer believed that benign peptic ulcer of the stomach is important as a precancerous condition. The evidence seems to point to the fact that any carcinomatous ulcer is malignant from the beginning.[13] Therefore, it is most advisable to watch roentgenologically and gastro-

scopically all seemingly benign ulcers that are on conservative medical management for complete healing. In the very early stages, a malignant ulcer may simulate a benign ulcer by both morphological methods of diagnosis, and under medical management give indications of healing, even to the point of disappearance of the niche on the roentgenographic plate, but when re-examined gastroscopically in a few weeks or few months after treatment, will then disclose its true identity. In the light of our present knowledge, preventive resection of a benign gastric ulcer to avoid development of carcinoma is hardly advisable.[10]

Benign tumors of the stomach are not rare. Various reports indicate about two per cent of the cases that are scoped have some form of a benign tumor. Of the epithelial type, polyps are the most common, vary in size, and may be multiple, are usually smooth and rounded, and are of the same color as the normal mucosa. They may have a broad base or pedunculated. The surrounding mucosa is normal or atrophic, never hypertrophic. Cauliflower-like papilloma are rare and often turn malignant. No symptoms unless complicated, large or penetrating or obstructing. In this category should be considered the pseudo polyposis, apparently of inflammatory origin growing in the soil of atrophic gastritis. They are usually multiple and occur in hemispherical excrescence.

Benign tumors of the connective tissue type (mesenchymal origin) include such types as fibromas, neuro fibromas, myomas, fibromyomas, lipomas, lymphomas, hemangiomas, and other. Fibromas are the most frequent of this group of benign tumors.

Of malignant tumors of the stomach, cancer is the most important. About 38,000 to 40,000 persons die annually of gastric carcinoma in the United States. About 95 per cent of the patients are between the ages of forty and seventy years. Approximately 30 per cent of all carcinomas found in men and 20 per cent of carcinomas found in women occur in the stomach.

The attitude concerning the prognosis of this fight seems to have changed in recent years, due to better x-ray and gastroscopic examinations and more early and radical surgery, a greater degree of optimism has arisen. About twenty per cent of all patients in whom a gastric resection is done for gastric carcinoma will survive longer than five years. This is gratifying and gives us hopes of discovering and removal of earlier questionable lesions that are found by special examination, such as x-rays and gastroscopy of patients suffering with minor abdominal distress.

Most carcinomas can be seen with the combination of both methods. Some may not be seen by the gastroscope, either because gastroscopy is not possible, as in cases of cardiac obstruction by the tumor, or in cases of leather-bottle stomach in which the stomach cannot be distended by air and therefore, no picture can be obtained, or because in a few cases the carcinoma may really be hidden, lying in one of the so-called blind spots of the stomach. On the other hand, some carcinomas may not be found by x-ray at the first examination and only disclosed by gastroscopic examination.

Balfour[1] states:

"The difficulties in early diagnosis are primarily responsible for the relatively high incidence of inoperable lesions and the difficulty of recognizing cancer of the stomach early in those cases in which symptoms are lacking probably almost always will be unsurmountable. It is possible, of course, that some easy and accurate routine method of examination of the stomach as part of a general examination may become the rule, just as roentgenologic examination of the lungs is an approach to the elimination of pulmonary tuberculosis.

"Gastroscopy has not only been a distinct aid in early diagnosis of cancer, but it has furnished valuable information on the significance of gastritis in relation to the development of carcinoma. One may expect that the continued use of this procedure will result in a better knowledge of the factors which predispose to cancer of the stomach."

If possible, it is best to establish not just the fact that an intra-gastric lesion is malignant, but to try and differentiate the different types before surgical intervention, as some types give on the average a very good prognosis and others a definitely bad prognosis.

Borrman[2] has given a macroscopic classification of gastric carcinoma which is now widely accepted and which is used widely in the gastroscopic description of gastric tumors. These types can be recognized in the gross specimen; they can be recognized easily at gastroscopic examination, if the whole circumference of the tumor becomes visible; and they can be recognized sometimes at x-ray examination, although the indi-

rect conclusions drawn from even the best relief pictures do not permit statements so definite as does the gastroscopic observation.

Type I carcinoma is of the polypoid variety, which is a rather sharply limited growth, mushroom type, with overhanging edges, surface nodular, ulcerates late, and metastesizes very late. Comprises about three per cent of all types of gastric malignancy. Quite amendable to radical surgery.

Type II carcinoma is of the ulcerating type, rather sharply demarcated, with a rolled nodular margin, deep irregular crater, the floor of which is covered with a dirty brown, dark red or gray exudate. The dark reddish, nodular margin of the ulcer may contain yellowish shallow erosions, and the lesion is quite sharply defined from the surrounding, usually atrophic, gastric mucosa. These lesions comprise about eighteen per cent of all gastric carcinomas and while they grow somewhat rapidly, they do metastasize rather late and therefore, afford extremely satisfactory end results, with cures of long duration if an operation can be performed at not too late a date.

Type III carcinoma of the stomach is an infiltrating lesion of the gastric wall with an irregular ulceration which typically has an irregular wall on one side and the ulceration becomes shallow and blends off into the surrounding mucosa on the other side. It is primarily more of an infiltrating lesion than Type II, and is more malignant. Tends to metastasize at an earlier stage. It comprises about seventeen per cent of the group of gastric carcinomas.

Type IV carcinoma is a diffuse infiltrating type of malignant tumor which comprises about sixty-two per cent of all cases, and is very rapidly growing and metastasizes quite early. It is not sharply limited and spreads rapidly to infiltrate most of the gastric wall, producing a stiff infiltration with formation of nodules and small dirty, necrotic, irregular ulcers. May be scattered throughout the surface or at times, a grayish, cobweb-like membrane forms over the surface without ulceration.

It must not be forgotten that in the beautifully sharp and colorful gastroscopic pictures we see living tissue, that the blood is circulating, that the color is not the dull, grayish pink of the gross specimen after surgery or autopsy, but that there are striking contrasts between the orange-red, brilliant, glistening, normal mucosa, and the yellow, or gray, or yellow-gray, or white, or dirty brown floor of an ulcerated surface.

Therefore, patients in the carcinoma age, in whom an ulcer niche is found at x-ray, should be examined gastroscopically. It probably is no longer necessary to point out that the therapeutic test alone, the watching of the roentgenologic niche becoming smaller, is not sufficient evidence that the ulcer is benign.

Close coöperation between the x-ray examination and gastroscopy will bring about the best diagnostic results concerning gastric carcinoma. X-ray examination, however, is widely known, while gastroscopy is in the beginning of its development. I hope that in a few years the valuable, close coöperation between the two methods will be feasible in all larger communities of this country. X-ray examination, however, will have such good results only if the routine, complete filling of the stomach is used, and if also the modern method of relief technique with compression and with the use of spot device is employed.

It is obvious from the vast experience accumulated in large hospital gastroscopic clinics, that very few cases of gastric carcinoma will be overlooked if the x-ray relief method and gastroscopy are used jointly. The extent of the tumor usually can be well demonstrated by the use of either one or the other method.

In spite of these gratifying developments in the field of early diagnosis, the differential diagnosis, in some cases, between gastric carcinoma and other diseases may be very diffcult even when both methods are employed. The difficulty in differentiating benign and malignant ulcer is well known, and here is a place in which gastroscopy is superior to x-ray examination.

In his paper on benign and malignant gastric ulcers, Palmer[7] came to the following conclusions: Although there is no pathognomonic sign to indicate the benign nature of a lesion, the total evidence available from careful study permits the clinical differentiation of benign and malignant gastric ulcer with a high degree of accuracy. In contrast with the general opinion, this differential diagnosis will usually be possible if all criteria are carefully considered, especially the gastroscopic findings.

Pollard and Scott[8] state that gastroscopy is of particular value in those patients in whom the x-ray examination has been unsatisfactory to either the roentgenologist, the clinician or both.

It is their belief that, if available, gastroscopy should be employed in any patient with an ulcerating lesion of the stomach which is not obviously a carcinoma by x-ray.

The differentiation between benign and malignant ulcerations is at times so difficult that no roentgenologist maintains infallibility. At the University Hospital, Ann Arbor, Michigan and also figures quoted by Drossner and Miller,[3] Walter,[15] and by Eusterman[4] would indicate that the percentage of error on the initial examination by x-ray is between 10 and 20 per cent.

When we review the progress in the understanding of gastric pathology, as it is seen by the gastroscope, then we realize what problems confront us and also that real advancement has been made in the last few years. The gastritis problem remains a broad one, with phases yet to be understood; the control of cancer, a grave one.

The multicentric origin of carcinoma is considered to be two to four per cent of the cases of gastric carcinoma and enhances the possibility of further malignant lesions developing in the remaining portion of the stomach after gastric resection and increases the importance of frequent, careful postoperative observations by the gastroscope.

The modern development of the x-ray method coupled with gastroscopy permits the recognition of almost every gastric carcinoma, even of very small size. It is advisable to have x-ray examination and gastroscopy promptly in patients with apparently minor but definite gastric disturbance if cancer control is to be advanced.

The differential diagnosis of diffusely infiltrative lesions may in the future be helped considerably by gastric biopsy when such has been perfected.

Errors in diagnosis by any one or all methods may at times be present. Even tissue resected for biopsy may be reported as benign by one and malignant by another pathologist. It is always better to err on the side of safety and to have a benign lesion explored and removed for possible malignancy when doubt exists.

Dr. Ewing stated:

"I am quite impressed, as a general pathologist, with the superior conditions under which the gastroscope works over any other method of examining the stomach, because quite clearly when the lesion is in the living body and there is a circulation and you can observe all the various colors and shades and irregularities in the surface examined, you have features which are not provided anywhere else—not even in the surgical operation does the surgeon observe that. I think it is this fact which guarantees the soundness of the principles of gastroscopy and will assure its future development."

The correct diagnosis of intergastric disease is extremely difficult, and the differentiation of benign and malignant lesions of the stomach most important. It requires the full coöperation of the clinician, the laboratory and the roentgenologist, and often the gastroscopist. Careful follow-up examination, after a period of supervised medical treatment and observation by the attending physician is of great importance. Follow-up examination by the x-ray and gastroscope is a most valuable adjunct.

The various types of gastritis which are frequent causes of digestive disturbance are only definitely diagnosed by gastroscopic examination, and particularly the atrophic gastritis which is considered by many authorities as a forerunner of gastric carcinoma, should be discovered and treated as early as possible.

All ulcerating gastric lesions or polypoid like growths discovered by x-ray examination that are definitely not carcinoma should be examined gastroscopically and surgically removed if questionable. Too frequently a malignant lesion has metastasized by the time it reveals itself as such by the x-ray.

In the future, our best weapon for the control of cancer of the stomach is the discovery of and the treatment of any precancerous condition of the gastric mucosa and the early and radical removal of all incipient and small carcinomatous lesions before they have spread to other parts of the stomach and metastasized to other organs.

The importance of the gastroscope as a special diagnostic aid in any intragastric pathology or functional derangement of the stomach where previously a definite and unquestionable diagnosis has not been established by other methods cannot be underestimated.

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The Surgical Treatment of Gall-bladder Disease

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The physiologic function of the gall bladder is concentration and storage of bile in the intervals between digestive activity. As a result of disease, either metabolic or infectious, this function may be altered or abolished, stones may form, and digestive disturbances occur. The rational treatment of cholecystic disease is cholecystectomy to remove the focus of infection which is principally in the wall of the gall bladder, and to remove the nidus for further stone formation. Symptoms, diagnosis and pathology will be reviewed. The management of acute cholecystitis will be discussed. A few details of operative technique will be mentioned.

■ I HAVE been asked to speak to you about disease of the gall bladder. This I propose to do from the point of view of the surgeon, which, as you know, has to do with removal of the diseased gall bladder. I should, therefore, like to discuss some of the diagnostic features of gall-bladder disease, the reasons why removal is the therapy indicated, and a little about some of the complications.

First of all it seems desirable to review the normal physiologic action of the gall bladder and of bile formation. The constituents of the bile are formed by the cells of the entire reticulo-endothelial system, but principally in the bone marrow, and to a lesser extent in the spleen and liver.[8] It seems likely that the last-named organ is concerned more with the excretion of bile than with its formation. In its passage from the circulating blood through the polygonal cells of the liver into the bile ducts, it undergoes some change, the nature of which is unknown. By the van den Bergh test the difference between the two sorts of bile can be determined, those bile salts which have not gone through the liver cells giving the so-called "indirect action," and those which have gone through those cells and then been reabsorbed into the blood, giving the "direct reaction." The presence of the "direct reaction" is, therefore, indicative of obstruction of the bile ducts, while the "indirect reaction" indicates failure of the liver cells to remove the bile salts from the blood, either due to excess production of the salts or to damage of the liver cells which prevents them from removing normal amounts from the circulation. It is thus indicative of hemolytic or toxic icterus.

The bile is apparently excreted by the liver at a relatively constant rate. In the absence of the gall bladder, it may be discharged into the intestine at a relatively constant rate. When a normal gall bladder is present, it is believed that the bile excreted by the liver enters the bladder through the cystic duct. There water is abstracted from it by the activity of the lining epithelium, thus concentrating the bile salts.[15] When the animal is fasting there is normally no bile discharged into the intestine, and the pressure in the common bile duct in the dog, for example, is about 140-170 mm. of bile. When food is taken there is an immediate flow of brown viscid bile into the intestine. This flow lasts only one to three minutes, but is followed by a secondary flow about ten to twenty minutes later which lasts for several hours. This flow is not continuous but comes in ozes and spurts.[12] From a study of such data it is now believed that the function of the normal gall bladder is to concentrate and store the bile secreted during the

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From the Department of Surgery, College of Medicine of the University of Cincinnati, and the Cincinnati General Hospital.

intervals between digestion until such time as it is required in the intestine.

In addition to direct observation, such as was described above in experimental animals, certain tests and therapeutic procedures confirm these events. The "A," "B" and "C" biles obtained by duodenal drainage and lavage are supposed to represent respectively the bile from the common duct, the concentrated bile from the gall bladder, and the bile from the hepatic ducts partly mixed with bile from the gall bladder. The correct sequence of these kinds of bile, and the examination of them, constitutes one of the tests of gall-bladder disease and the procedure may be used therapeutically to induce so-called internal non-surgical drainage of the gall bladder.

Even more significant and useful is the Graham-Cole test, both for diagnosis and for its aid in helping appreciate the function of the gall bladder. You all know the essential features of this test. A dye is either swallowed or given intravenously. It is excreted in the bile and is sufficiently radio-opague to cast a shadow if it enters the gall bladder in adequate amount and concentration. Many studies of normal and pathologic gall bladders by this test have shown that normally the shadow of the viscus is first more or less indistinct. Later it becomes slightly smaller and much more clear-cut, which is interpreted as concentration of the bile. If food is given, especially food containing oil or fat, the shadow diminishes and finally disappears in thirty to forty minutes, interpreted as the emptying of the gall bladder due to ingestion of food. As a diagnostic test, complete failure of the gall bladder to visualize indicates either (1) failure of the dye to be absorbed, (2) failure of the liver to excrete it, (3) emptying of the gall bladder due to ingestion of food during the progress of the test, or, (4) a non-functioning gall bladder. One can usually eliminate the first three possibilities or take them into consideration in evaluating the significance of a non-visualized gall bladder. By this test stones also may often be demonstrated. In a bladder which is still able to concentrate bile, the stone or stones may be less dense than the dye, and by excluding it, cast negative shadows, or, they may absorb the dye and cast positive shadows best seen after the dye is expelled. The interpretation of abnormalities of shape, size, contour, partial concentration, rate of emptying, et cetera, as shown by the test requires much experience and skill. It is probably our most important single laboratory aid in diagnosis, but must not be regarded as the sole criterion of the presence or absence of cholecystic disease to the exclusion of clinical history and examination.

Some years ago Judd suggested that the term cholecystic disease rather than cholecystitis be used to designate abnormal conditions of the gall bladder for the reason that there seem to be two main sorts of gall-bladder disease—those associated with disturbances of cholestrin metabolism and those due to definite infectious processes. In disease due to disturbance of cholestrin metabolism one may find cholestrin deposits just beneath the epithelial lining of the gall bladder in the submucosa. The wall is generally not thickened, but if the viscus is opened the cholestrin can be seen as yellow flicks through the red mucosa which accounts for the name "strawberry gall bladder" being applied, though a better term is "cholesterosis." Even without actual stone formation such a gall bladder is the cause of or is associated with digestive disturbances which will be described later. When stone forms in this type of cholecystic disease, it is likely to be a solitary stone, oval or round in shape, light in color, and chemically made of almost pure cholestrin. The gall bladder often retains its function of concentration of bile with a stone or stones of this type.

The stones which occur in the course of infectious cholecystic disease are usually made up principally of bile pigments, though they may also contain cholestrin. They are usually multiple, dark in color and irregular in shape. In this type of disease the wall of the gall bladder is generally thick and fibrotic.

Still another type of stone needs to be mentioned. This is the stone which casts a positive shadow in the plain x-ray due to a deposit of calcium on the outside of a stone whose center is made up of cholestrin or bile pigments. As Phemister and his associates have shown this deposition of calcium occurs as a rule only when the cystic duct is occluded.

The symptomatology in the two varieties of cholecystic disease may be similar, except that in the infectious type, the patient may have acute exacerbations with fever and leukocytosis. In

either type, colic and digestive disturbances may be present, but fever and leukocytosis do not occur unless infection is present.

Within the past few years our knowledge regarding how infection reaches the gall bladder has been considerably increased, though there is much that still remains obscure or is subject to doubt and controversy. The possible avenues are (1) the bile and biliary ducts, either ascending or descending, (2) the blood stream, (3) the lymphatics, (4) direct extension from neighboring structures. Apparently infection may reach the gall bladder by all four of these routes, but there is increasing clinical and experimental evidence that the bile and bile ducts which were long considered as the main pathway of infection are of relatively little significance, and that the blood and particularly the lymphatic channels are probably the more important. Chiefly on the basis of experimental work on animals it is now believed that bacteria which ultimately reach the gall bladder, go first to the liver where they are filtered out, and then pass to the gall bladder by way of the lymphatics. The work of Peterman[11] in this connection is especially striking. He has shown that bacteria in the portal blood stream are particularly likely to reach the gall bladder. This, of course, raises the question whether areas of infection in the portal area such as appendicitis, pancreatitis, duodenitis, colitis, et cetera, may not be the principal foci of infection giving rise to cholecystitis. Rosenow[14] believes that most infections reach the gall bladder through the blood stream, and that the localization there is a result of the specific affinity of the particular strain of organisms for the gall bladder. In spite of these experimental findings we must still admit that we do not know with certainty the method or methods by which infection reaches the gall bladder. The experimental production of infection in the gall bladder by injecting large numbers of bacteria into the portal blood stream is not comparable to any clinical happening except rare fulminant infections. It has never been shown, for example, that cholecystic disease is especially prevalent in persons who have previously had acute appendicitis. The frequent occurrence of chronic cholecystitis with chronic appendicitis does not prove that the former is secondary to the latter, nor has it been shown that a chronically infected appendix discharges bacteria into the blood stream; certainly it does not in the numbers that it is necessary to use in experimental work.

There is, of course, a very definite association between cholecystic disease and changes in the liver which are designated by the term hepatitis. In the operating room you are all familiar with the whitish scars visible on the liver in cases of long-standing cholecystic disease. It has been amply demonstrated, however, that microscopic changes can be found in the liver in the absence of gross changes of the surface or even of a freshly cut section. These changes may also be present in the absence of any evidence of hepatic insufficiency as determined by the methods which are now available. The changes seen microscopically consist essentially of infiltration of lymphocytes in the periductal spaces, combined with scarring and fibrosis. How frequently these changes occur in conjunction with cholecystic disease is not clear. According to Graham and his associates, it approximates 100 per cent.[10] Whether it precedes or succeeds the changes in the gall bladder is not entirely certain, but it probably comes first in at least some cases. There is an intimate lymphatic connection between the liver and gall bladder, so that infection in one can easily pass to the other. The function of the liver in detoxification of bacteria and their poisons probably explains in part the changes in the liver described above, as the liver tissue suffers in dealing with these substances. An infected gall bladder is said to be a constant source of renewed infection to the liver both by way of the lymphatic connections and by way of the portal blood stream, and its removal may take away a potent source of infection of the liver.

Of significance from the standpoint of treatment is the location of the infection in the gall bladder. It has been shown that the principal site of infection is not in the bile, not in the lumen, not in the crypts of Luschke, but deep in the wall of the gall bladder. In a study of 200 consecutive cases with stones, Judd[6] was able to obtain positive bacterial cultures from the bile in 14 per cent, from the stones in 31 per cent, and from the macerated wall in 49 per cent. Microscopic examination shows that this portion of the wall is the site of the chief pathologic change. Bacteria injected into the portal stream can be stained in the tissue at this level, and re-

covered from the wall when they cannot be recovered from the bile. These and other observations lead to the belief that the infection lodges chiefly in the wall of the gall bladder, though it seems unlikely that infection lies only in that location.

In the diagnosis of cholecystic disease the history is an important aid. The disability usually consists of indigestion, flatulence, a feeling of fullness after meals, particularly after excessive or injudicious intake of foods. The patient soon learns that certain foods have to be avoided, for if they are ingested an attack is almost certain to occur. Chocolate, eggs, cabbage, beans, fried and greasy foods are the most common offenders. These attacks of indigestion may be isolated or they may be more or less continuous and may be accompanied by fever. They are relieved by rest, by abstaining from food, by the taking of small doses of saline cathartics, and also by duodenal drainage after the method of Lyons. These are the commonly accepted methods of medical treatment. In general we might say of them that they alleviate the symptoms, and often control them very satisfactorily. In the vast majority of cases and especially in those associated with stones, they must be regarded as palliative and temporary measures, but not curative ones. Sooner or later most patients with stones have to have surgical treatment either when their symptoms become too intense or when they tire of the continued disability and treatment.

In addition to the symptoms just mentioned, many patients suffer attacks of acute gall-bladder colic—intense cramp-like pain which begins in the region of the gall bladder and radiates around the ribs or through the body to the right shoulder blade. This is often associated with nausea and vomiting, and may require morphine for alleviation. It is usually due to a stone becoming impacted in the cystic duct, and the colic terminates when the stone has passed down into the common duct or into the intestine, or has slipped back into the gall bladder. In the noninfectious type of stone, fever and leukocytosis are not present, but in the infectious case they may be present and marked. Jaundice is generally absent or slight unless there is stone in the common duct. When present without stone in the common duct it is usually due either to a large stone pressing on the common duct from without, or to inflammatory congestion of the ducts and hepatitis. If the stone remains impacted in the cystic duct, the gall bladder, in the absence of infection, becomes filled with the mucous secretion of its own epithelial cells, and the pathologic condition is called hydrops of the gall bladder. If the contents of the viscus is infected, empyema of the gall bladder may develop.

Examination of the abdomen between attacks may be entirely negative, or there may be slight tenderness on deep pressure over the region of the gall bladder, though during an attack the tenderness may be quite marked and associated with muscle spasm and rigidity. The gastric analysis is not typical, but there is often decreased acidity. Duodenal drainage may show deviation from the normal, either absence of the typical color changes, the so-called "A," "B" and "C" bile, or the presence of abnormal constituents—pus cells, bacteria or cholesterin crystals. Roentgenologic examination of the stomach and duodenum is often negative, but may show evidence of adhesions surrounding the duodenum. Plain films of the region of the gall bladder are usually negative, for even if stones are present they are seldom sufficiently radio-opaque to cast a shadow. The introduction of the Graham test has been of tremendous aid in helping establish the diagnosis.

In the treatment of chronic cholecystic disease there is a consensus of opinion among the leading surgeons both in this country and abroad that cholecystectomy is the method of choice. This opinion is based on a number of things some of which have already been hinted at. The most significant of these is the site of infection in the gall bladder. Experimental study in the laboratory, and pathologic study of clinical material show that this infection is located principally in the wall of the gall bladder so that neither internal nor external drainage can hope to remove it, and cholecystectomy remains the only way of doing so. Another important reason for removing the gall bladder, especially in those cases where stones were present, is that most stones are formed in the gall bladder and more stones may very well develop again in a viscus which has been drained surgically. Another important point is the question of function of the gall bladder before and after surgical drainage. Repeated reports have appeared of groups of patients studied by the Graham test at various in-

tervals after cholecystostomy. They all show that a gall bladder which failed to function before drainage also fails to function after drainage. A few which functioned more or less normally before drainage may continue to function afterwards. In no case is function better after drainage than before.[3,4] If function of the gall bladder cannot be restored by any procedure known to us, and, furthermore, if in addition to being useless the gall bladder is also a source of discomfort and even danger to the patient, then certainly it should be removed.

The intelligent physician wishes to know what physiologic and anatomic changes occur following cholecystectomy. This has been found to vary considerably depending on the condition of the gall bladder prior to operation. If the gall bladder is capable of functioning normally, a number of changes occur, but if it is not functioning, the same sort of changes that occur after removal of a normal viscus have already taken place. In other words, the changes about to be described occur whether the gall bladder is absent so far as function is concerned although anatomically present, or whether it is absent in fact, due to surgical removal. In the walls of the major bile ducts are numerous diverticulæ called parietal sacculi. As a result of functional or anatomic absence of the gall bladder these dilate considerably and thus increase the capacity of the bile duct system.[2] Bile is usually discharged into the duodenum continuously after removal of the gall bladder with increase in the rate of flow during periods of digestion. It is thinner and more watery. Gastric acidity remains unchanged following cholecystectomy, but there is often increase in pepsin. Digestion of fats is less complete in experimental animals after removal of a normal gall bladder. There is some evidence that there is an increase in the virulence of intestinal bacteria particularly those of the B coli group, which may be due to the absence of concentrated bile in the intestine. It is to be re-emphasized that the changes just mentioned are most striking after removal of a normal gall bladder. If a nonfunctioning viscus was present before operation, many of these changes have already taken place.

In addition to the chronic forms of cholecystic disease which have been considered, every now and then patients develop acute infectious attacks. These are usually ushered in by a typical gallstone colic, with pain, nausea, distention and vomiting, but in addition there is fever and leukocytosis. The pain is usually more intense and persistent than with the ordinary attack and the fever may be preceded by a chill. Not infrequently there is slight but definite jaundice. Examination of the abdomen shows it to be slightly distended as a rule, with extreme tenderness in the region of the gall bladder, muscle spasm and signs of a localized peritonitis. If the patient can relax sufficiently, a distended gall bladder can be felt which is very tender to pressure. When such an attack occurs, it has been the custom for years to treat the patient conservatively in the hope that the attack will subside, and since many attacks do subside spontaneously the advice to withhold operation in such cases is generally recommended in textbooks. However, many surgeons believe that most patients with this sort of an attack should be operated upon promptly.

Pathologically there is usually a stone impacted in the goose neck or cystic duct with infection bottled up inside the gall bladder, and the viscus may become filled with purulent exudate, a condition known as empyema of the gall bladder. The coincident infection leads to edema and congestion at the neck of the gall bladder and even to infection extending up the biliary radicles into the liver, which is called cholangiitis. This may cause low-grade jaundice. The infection and congestion may in addition lead, just as in appendicitis, to disturbances in the blood supply to the gall bladder, either by pressure on the cystic vessel or to actual thrombosis. When this occurs, gangrene of the wall of the gall bladder may develop. The advocates of delayed operation or no operation during the acute attack point to the fact that gangrene and perforation of the gall bladder occur infrequently, and that when they do develop, the progress is relatively slow so that adhesions generally have formed, and if the gall bladder ruptures, an abscess outside the gall bladder is formed, the so-called peri-cholecystic abscess. Those who recommend prompt operation in such circumstances point out that if the condition is recognized early, operative removal of the gall bladder is simple and easy to perform, the mortality rate is low and long convalescence and complications are avoided. For many years

I have believed in early operation in patients with acute cholecystic disease.[17] Within the first forty-eight hours of onset, the operation is usually easy to perform, the edema of the wall of the gall bladder facilitates dissection as cleavage planes develop easily. There is increased vascularity and fragility of the vessels, but by proper technique ligation of the cystic artery can be accomplished readily. The convalescence is generally rapid and uncomplicated. In patients seen 48 hours after onset of the attack, cholecystectomy is usually not feasible or recommended, but drainage of the gall bladder may cause the inflammation to subside and prevent perforation of the gall bladder and formation of a peri-cholecystic abscess. Those who recommend nonoperative treatment emphasize that free perforation of the gall bladder is uncommon and with this I agree. However, there has been no published report of which I am aware that gives the mortality rate in cases of peri-cholecystic abscess. Patients with this condition that I have seen are usually extremely ill, the mortality rate among them has been high, and those who recover generally go through a stormy and prolonged convalescence.

In the management of cases of acute cholecystitis seen early I should suggest the following plan: The patient is placed in bed, is given nothing by mouth except sips of water, but fluids are given parenterally. A careful evaluation should then be made of the patient's clinical signs and symptoms such as degree of muscle spasm or rigidity, size and tenderness of gall bladder if palpable, amount of spontaneous pain, temperature and leukocytosis. If the pain is very acute and persistent in spite of opiates, gangrene of the wall of the bladder is probably occurring and prompt operation is indicated. This is especially true of patients over sixty years of age in whom gangrene is more apt to occur early. If the acuteness of the attack moderates within six to twelve hours, operation may be deferred, but if the symptoms or signs persist or get worse I believe operation should be advised. If one is sure of the diagnosis, early operation but not emergency operation is recommended in every case because with such an acute attack operation will sooner or later be necessary, and it is easier to perform during the early acute stage than five days to several weeks later, after adhesions have formed, and the convalescence is usually short and uncomplicated.

I have so far made little or no mention of jaundice and its relation to gall-bladder disease. This is because jaundice is not a symptom of cholecystic disease, but is rather one of the complications. There is insufficient time to consider all the aspects of jaundice or the differential diagnosis of the various types. That which occurs in association with cholecystic disease is usually due to a stone in the common duct. The typical history is one of jaundice associated with colicky pains both of which tend to be remittent or intermittent. Often it is accompanied by chills and fever, due to an associated cholangiitis. The typical temperature chart is characteristic. The chills come at irregular intervals, and are followed by high fever which rises rapidly only to subside just as promptly. This gives a number of steeple-like curves to the chart. In its typical form it is known as Charcot's intermittent or remittent fever, or simply, as Charcot's fever. In patients with marked jaundice, and those with stone in the common duct, the danger to the patient is considerably increased, whatever the treatment.

Many a sufferer from gall-bladder disease who has ultimately died of an operation would probably have survived if operation had been done in an early, uncomplicated stage. Many patients are themselves at fault by refusing operation, but only too often they are kept from operation by a physician who gives them an optimistic outlook for cure without operation, which is not justified. Some years ago Alvarez[1] in reviewing a group of sixty cases found that the average duration of the disease was nineteen years before operation was done. He came to the conclusion that gall-bladder disease was acquired in youth and early adult life, and was recognized and adequately treated in middle and late adult life.

As to the operative technique I have only a few words. The general technique of cholecystostomy and cholecystectomy is well known to you. It is always desirable to divide the cystic duct and artery before removing the gall bladder in order to avoid forcing small stones from the bladder into the common duct and to reduce bleeding. In many cases this may, however, not be the safest way because of the danger of injury to the common duct. When dense adhesions are present as they often are in long-standing cases or those previously operated upon,

so that isolation of the cystic duct is difficult, I always begin the dissection at the fundus and carry it down to the ducts. In extremely difficult cases, the gall bladder may be opened, clamps placed on the margins and a finger inserted into the lumen as a guide. In this way the bladder can be freed somewhat as one dissects the sac of a hernia.

Some surgeons close the wound without drainage following cholecystectomy, an operation to which has been given the name "ideal cholecystectomy." I have never been able to convince myself that this is a wise procedure, and I do not employ it. Whether or not one does do so, depends on whether one is willing to run the risk of leakage of bile. In a simple, easy case without many adhesions, or without much infection, with satisfactory ligation of the cystic duct and artery, it is a perfectly safe procedure except for one uncontrollable factor, namely, the danger of bile oozing from the bed in the liver from which the gall bladder has been freed. Every now and then one finds drainage of bile occurring following the simplest case. Recently Fowler[5] reported on his experience with nondrainage following cholecystectomy. The essential data are as follows: 543 cases were drained, with 15 deaths —a mortality rate of 2.7 per cent; 240 cases were not drained, with eight deaths—a mortality rate of 3.3 per cent. In the follow-up study of these groups there were available 406 drained cases and 134 undrained. Of these, 94.8 per cent of the cases drained report themselves as well, as contrasted with 89.6 per cent of the undrained cases. The author's conclusion was that it was wiser and safer to drain.

Surgery of the common duct at its best is none too easy and requires expert and careful work. At its worst, it ranks with the most difficult surgery and even when good immediate results are obtained the late end-results may be disappointing. Stone in the common duct can usually be recognized by the experienced surgeon by palpation along the course of the duct. If from the history and examination stone in the common duct is strongly suspected, but cannot be located by palpation, the common duct should be explored. The exact criteria to be used in deciding when to open the common duct vary from one clinic or individual to another. The policy in our clinic has been relatively conservative and the following plan is used: The common duct is opened and explored, (1) if a stone can be felt in the duct, (2) if the patient has given a definite history of jaundice or is jaundiced at the time of operation, and (3) if the common duct is dilated. We do not regard the presence of small stones in the gall bladder and a patent cystic duct as a positive indication for opening the common duct unless one of the three conditions just mentioned is also present.

It is usually advisable to drain the common duct after incision or prolonged manipulation. In 1921 Reid[13] and Halsted reported a method of draining the common duct through the stump of the cystic duct, a procedure which they termed cystico-choledochostomy. This method has not been given the prominence in the literature which it deserves. The technique is simple and is illustrated by the lantern slides. After all manipulations of the common duct are completed a small soft rubber catheter, about F 12 or 14, is passed through the stump of the cystic duct and directed downward in the common duct. The incision in the common duct is then closed accurately and carefully by two rows of sutures. We generally use an inner continuous suture of very fine chronic catgut, and a second layer of interrupted fine silk. The catheter is then anchored to the cystic duct by an encircling transfixion suture of fine catgut. We use this method routinely in our clinic in all common duct cases, with the utmost satisfaction. It reduces the time and amount of bile drainage which, when prolonged and copious, is so debilitating to the patient. It thus shortens convalescence and hospitalization and reduces mortality. The long narrow tract usually remains water tight, so that bile leakage around the tube seldom occurs. In most cases the accurate closure of the common duct results in per primam healing, which gives the minimum amount of scarring, and therefore reduces the likelihood of subsequent stenosis of the duct, that much dreaded complication of gall-duct surgery.

In conclusion, I should like to make just a few remarks regarding mortality rates and results following cholecystectomy. I regret that I am not prepared to give you actual figures from our clinic or from my own private practice. In general, however, the mortality rate of cholecystectomy in simple uncomplicated cases has been gradually reduced over a period of years till

(Continued on Page 1112)

Our Medical Veterans' Readjustment Program

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President's



Page

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A Medical Veterans' Readjustment Program to aid returning medical officers of Michigan in a threefold manner was created by the House of Delegates of the Michigan State Medical Society at its 1944 Session in Grand Rapids.

The program's triple activity will assist medical officers with problems of (a) relocation; (b) finances; (c) postgraduate work.

A counselor—a Doctor of Medicine—is to administer the program which will be under the direction of The Council of the State Society.

The House of Delegates, in its wisdom, instructed that a per capita assessment of five dollars be levied in 1945 on every active member of the MSMS to defray the expenses of this postwar veterans' program. Universal enthusiasm for this new and progressive project of the State Society—as well as complete accord with the House of Delegates' decision to continue the ten-dollar assessment for necessary public education activity—has been voiced by members of the medical profession.

Officers of the Medical Corps who are separated from service are invited to utilize this new MSMS Readjustment Service provided for their benefit. The State Society feels it a great privilege and honor to serve our medical veterans upon their return to civilian life.

A. S. Brunk

President, Michigan State Medical Society

EDITORIAL

"MICHIGAN'S MEDICAL PLAN SETS PACE FOR THE NATION"

"In five years the Michigan Medical Service, biggest voluntary venture into the field of medical economics, has become the nation's No. 1 setup of its kind. . . Doctors did everything to put the service within easy reach of all persons. . . . In Michigan, its originators hope that widespread adoption of the prepaid medical plan will cause the defeat of any proposed national legislation designed to put the government in charge of dispensing medical services. . . . There was no difficulty in getting doctors to accept this modified form of social medicine. They set up the plan themselves. . . . The Michigan Medical Society spent thousands of dollars over a period of ten years investigating the possibilities of extending medical service to groups ordinarily unable to afford it."—*The Detroit Free Press,* Sunday, October 15, 1944.

▪ A few years ago an article in the public press speaking favorably of the medical profession and its doings would have been a museum article. Now these are appearing frequently. Either the profession has succeeded in selling its good will and good acts, or the bureaucrats who are constantly trying to dominate and control have lost their string, or have met their match. We believe the latter is the case. Our medical service plans have shown that medicine can do its own job without interference. We have demonstrated in Michigan that we have something to offer the public which is far better and much more practical than the dream clouds of the star gazers.

We have been "shown" the Kaiser plan for medical care (DeKruif: "Kaiser Shows the Doctors") and told of its great advance, of its complete care and low cost, of how that plan could be extended to cover so much of the nation. We have before us Kaiser's latest program, the prospectus on which they are selling that plan to the workers of the Kaiser Ship Yards. They are selling "complete health service" except tuberculosis and insanity. Hospital services are available only at the Northern Permanente Hospital located just east of the Vancouver Yard. "The member has available the services of any doctor on the Permanente Hospital staff, or any doctor of the Clark County Medical Society whose name appears in this booklet." The cost is 80c per week for adult member, or wife or husband of member. Children up to three 50c per week each. Children over sixteen are listed as adults.

"Pre-existing chronic illnesses are covered provided the member has been on the new or old plan for 90 days." "A ten-dollar charge will be made for the removal of tonsils and adenoids for child members of the plan under sixteen years of age." "A fifty dollar charge will be made for a maternity case provided the member has been continuously on the plan for at least 90 days prior to entering the hospital." These rates are higher than those in Michigan, and include two extra assessments that we do not. This is the first time the Kaiser employes could get services for the family.

This is the outstanding plan, other than government medicine that has been held up to us as a mark to be attained. We have no fears there.

We should be proud of Michigan Medical Service. Mr. John F. Hunt in his analysis of the public opinion survey, published last month, gave M.M.S. much credit for the favorable opinion he found in Michigan in contrast to other states.

We have a very successful growing concern, we must keep it so. If we do that it can render whatever service our members determine is needful. It can and will be able to outbid the government political setup.

GOVERNMENT MEDICINE AGAIN

▪ The American Public Health Association at its annual meeting in New York on October 4, 1944, adopted a report favoring a federal plan of compulsory public health insurance.* This was actually the action of the Governing Council by a vote of 49 to 14. The action was taken in the name of the 7,493 members, of whom only 1,571 are Fellows and have a vote, if they are present. The opposition urged that before taking action they consult the medical and dental professions, who would be most vitally interested in the ultimate plan. But this was not done.

Much as we would like to respect the Ameri-

*(The Report as adopted is on page 441, *Journal of the AMA,* Oct. 14, 1944, and an Editorial on page 434. Read them.)

can Public Health Association we cannot do so. They are decidedly not our friends. Many of their members are members of the American Medical Association, which they know is opposed to this method of government medicine. We think some resignations are in order. This A.P.H.A. is the group that hopes to have control of the bureaucracy in Washington which will administer the Political Medicine that will serve this nation if their recommendation succeeds. The very fact that they ignored the most interested groups in arriving at their policy shows that we have nothing to look forward to in case that ideology should prevail.

This Governing Council contains the names of some of our old "friends" of other controversies: Joseph W. Mountain, M.D., Edwin F. Daily, M.D., I. S. Falk, Ph.D., George St. J. Perrott, Nathan Sinai, D.P.H., to name a few, none of whom are in the private practice of medicine. Salaried bureaucrats, teachers, hospital superintendents, government administrators are not the ones to determine the way medicine shall be practiced in the future. We know their schemes and must circumvent them.

We cannot urge too strongly that every one of our doctors study the material we have given you, and determine where he can help. This is not a job only for your officers. It is a job of the medical profession, and every one of us is involved. It is our practice that is being criticized and its very existence threatened.

THE MICHIGAN PUBLIC OPINION SURVEY

▪ The Michigan Public Opinion Survey, recently completed and just released, shows a quite generally favorable public attitude towards medical-hospital service plans of the prepayment variety and sponsored by the medical profession and hospitals. But a large percentage of our people want government-controlled medical-hospital plans. Study of the reasons for this shows largely that they want security and confidence that they will be taken care of when calamity strikes. The survey also shows that only one person out of four knows about the medical plan, but we have sold our medical services to fifty-four per cent of them. This would seem to point that we have an article for sale that sells very well, but we have not yet pushed it. Yet with the inadequate coverage of the people in our educational efforts we have reduced the number of those favoring government control from fifty per cent as experienced in California to thirty-nine per cent here in Michigan. This is a contrast to the *Fortune* Magazine survey covering the whole country which showed that 74.3 per cent of the people favored government provision of medical care through taxes. Here are facts that show some definite results from the intensive work done in Michigan. *But we have not gone far enough.*

We in Michigan have demonstrated that the Wagner-Murray-Dingell Bill is not necessary. *But we have not gone far enough. We must spread the gospel throughout the nation, as well as do a better job here at home.*

Our survey shows a desire for medical care in the hospital, which the Michigan Medical Service has foreseen; it has provided just such a certificate. As Michigan Medical Service found when it established the present plan, there is no actuarial data upon which to write such a policy. Michigan Medical Service has determined to sell a limited number, forty or fifty thousand, then service those certificates, accumulating our actuarial information in a group that will not bankrupt us, as our other plan nearly did. This is sound practice, and we hope to learn our lessons, and be able to offer this service to all our patrons in reasonable time.

Such a plan and experiment can and will give us the necessary know-how to expand into offering a "Package" more in keeping with what government is talking about.

Another service now being requested is the possibility of selling nation-wide contracts covering surgery and hospitalization for the employes of companies having national distribution of their service. Michigan Medical Servce has found some companies who demand a policy of this scope. There is none of the voluntary type, because there are states where the medical service plan is not yet established.

The Blue Cross service plans through their national associations are especially confronted with this dilema and have proposed the establishment of a Surgical Service plan to be sold in states where no medical plan now operates. This was proposed some months ago, but rather died by the way. However, it is now being revived and

a conference has just been held in New York, the reports of which are not yet available.

We believe this should not be done by the Blue Cross Plans. There would be the same complaint that we had in Michigan that the hospitals were offering medical service. The two plans are best sold together by one sales organization, as is being done in Michigan, but the surgical plan should be sponsored by other surgical plans, of which there are several now successfully operating. None of our surgical plans have as yet accumulated enough funds to finance the new national plan, and they might have to have help from the Blue Cross plans, with proper interlocking boards and controls, but the plans will go farther, and be adopted more generally if they are sponsored through the medical profession.

The above is a service we in Michigan must endorse and help get into being, because this service must be made available if we are to forestall more active encroachment by government in the way of Wagner-Murray-Dingell, or what is more threatening to Michigan right now, the proposed amendment to our State Constitution.

Mr. Hunt in his paper closed with these words: "I might even say—if the facts revealed by this investigation fail to spur you to ultimate effort in perfecting what you have here in Michigan—if they fail to make you just as active in fighting for and providing your kind of medicine on the national stage, the money spent for this investigation will not only be wasted but your profession—as you know it and as you want it—may ultimately be laid waste as well."

POLITICAL MEDICINE

▪ If the medical profession is to retain any vestige of its independence, of its honorable tradition of leadership in public affairs, of being counsellor of its followers, it must WAKE UP. Aggression of every sort is showing its sinister head. There was the Wagner-Murray-Dingell Bill to take over the practice of medicine on a national scale. For the time being that is in the background, but only for the time being. All of these men will be in the next Congress, with the stamp of approval of the voting public. What more logical than that they should take their reelection as a mandate from the people that they carry on in the course in which they have so far made the most noise?

Then there is the threatened Constitutional amendment to the Social Security program of the State of Michigan. Some of our doctors of medicine have been lethargic to this proposal, thinking it was so fantastic it could not possibly be a threat to worry about. A study committee of the State Medical Society has been working on this measure and they have arrived at an opposite view. It has real dangers. If passed, and make no mistake it COULD pass, it will put the medical profession of Michigan out of business. Every one of us will be the hired man of the Commissioner of Social Insurance. Complete medical, obstetrical, surgical, dental, nursing, hospital and pharmaceutical care will be provided for every "normal citizen."

We may feel secure because *"this cannot work."* That may be true; we think it is; but it looks as if an attempt will be made to make it work. The disruption of all our economics, personal or public, in making this attempt at social revolution will be appalling. WAKE UP, Doctor.

ON THE RUN . . .

Two penicillin inactivators are now known: one is the enzyme penicilinase; the other is found in penicillin resistant strains of Staphylococcus aureus.

Stellate ganglion block has been suggested as a means of increasing blood flow in the damaged area following cerebral thrombosis.

Relief from angina pectoris may sometimes be obtained through control of an underlying hyperthyroidism or anemia, reduction of excessive overweight, or support of a protuberant abdomen.

Pulmonary tuberculosis is much more of a surgical disease than is duodenal ulcer; 50 to 80 per cent of the former are now treated surgically as against 10 to 15 per cent of the latter.

In supposed functional diarrheas, a high blood sedimentation rate indicates organic trouble in the bowel.

Prostatic calculi occur as frequently in malignancy of the gland as in benign hyperplasia.

Renal tuberculosis should be suspected in every instance of pyuria.

Carcinoids (argentaffine tumors) of the small bowel produce a characteristic sharp angulation in x-ray studies of the involved segment.

Cutting of pleural adhesions has more than doubled the instances where an ineffective pneumothorax has been made effective.

—Selected by Wm. S. Reveno, M.D.

MICHIGAN STATE MEDICAL SOCIETY

Seventy-ninth Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

Pantlind Hotel, Grand Rapids, Michigan

Monday Evening Session

September 25, 1944

The first session of the House of Delegates of the Michigan State Medical Society convened at eight thirty-five o'clock in the Ballroom of the Pantlind Hotel, Grand Rapids, Michigan, with P. L. Ledwidge, M.D., M.D., Detroit, the Speaker, presiding.

THE SPEAKER: The House will please come to order. Is the Chairman of the Credentials Committee ready to report?

I. Record of Attendance

	COUNTY	DELEGATE	MEETING 1st	2nd	3rd
1.	Allegan	W. C. Medill	x	x	x
2.	Alpena-Alcona-Presque Isle	F. J. O'Donnell	x	x	x
3.	Berry	C. A. E. Lund	x	x	x
4.	Bay-Arenac-Gladwin-Iosco	C. L. Hess	x	x	x
		F. H. Drummond	x	x	x
5.	Berrien	D. W. Thorup	x	x	x
6.	Branch	R. L. Wade	x	x	x
7.	Calhoun	A. T. Hafford	x	x	x
		B. G. Holtom	x	–	x
8.	Cass	S. L. Loupee	x	x	x
9.	Chippewa-Mackinac	B. T. Montgomery	x	x	x
10.	Clinton	W. B. McWilliams	x	x	x
11.	Delta-Schoolcraft	J. J. Walch	x	x	x
12.	Dickinson-Iron	L. E. Irvine	x	x	x
13.	Eaton	P. H. Engle	x	x	x
14.	Genesee	D. R. Brasie	x	x	x
		F. E. Reeder	x	x	x
		Henry Cook	x	x	x
		A. C. Pfeifer	x	x	x
15.	Gogebic	W. E. Tew	Not Repres'd.		
16.	Grand Traverse-Leelanau-Benzie	R. T. Lossman	x	x	x
17.	Gratiot-Isabella-Clare	M. G. Becker	x	x	x
18.	Hillsdale	L. W. Day	x	x	x
19.	Houghton-Baraga-Keweenaw	Alfred LaBine	x	x	x
20.	Huron	C. W. Oakes	x	x	x
21.	Ingham	C. F. DeVries	x	x	x
		L. G. Christian	x	x	x
		R. S. Breakey	x	x	x
22.	Ionia-Montcalm	W. L. Bird	x	x	x
23.	Jackson	J. J. O'Meara	x	x	x
		C. S. Clarke	x	x	x
24.	Kalamazoo	R. J. Armstrong	x	x	x
		L. W. Gerstner	x	x	x
25.	Kent	R. H. Denham	x	x	x
		L. F. Sevey	x	x	x
		A. B. Smith	x	x	–
		A. V. Wenger	x	x	x
		W. B. Mitchell	x	x	x
26.	Lapeer	D. J. O'Brien	x	x	x
27.	Lenawee	E. T. Morden	x	x	x
28.	Livingston	H. L. Sigler	x	x	–
29.	Luce	H. E. Perry	Not Repres'd.		
30.	Macomb	Wm. A. Sibrans	x	x	x
31.	Manistee	E. A. Oakes	x	x	x
32.	Marquette-Alger	W. H. Vandeventer	x	x	x
33.	Mason	C. A. Paukstis	x	x	x
34.	Mecosta-Osceola-Lake	Paul B. Kilmer	x	x	x
35.	Medical Society of North Central Counties	R. C. Peckham	x	x	x
36.	Menominee	S. C. Mason	x	x	x
37.	Midland	Harold H. Gay	x	x	x
38.	Monroe	T. A. McDonald	x	x	x
39.	Muskegon	E. N. D'Alcorn	x	x	x
		Harold Dykhuizen	x	x	x
40.	Newago	H. R. Moore	x	x	x
41.	Northern Michigan	George Wood	x	x	x
42.	Oakland	R. H. Baker	x	x	x
		P. E. Sutton	x	x	x
43.	Oceana	M. G. Wood	Not Repres'd.		
44.	Ontonagon	W. F. Strong	Not Repres'd.		
45.	Ottawa	A. E. Stickley	x	x	x
46.	Saginaw	C. E. Toshach	x	x	x
		L. C. Harvie	x	x	x
47.	Sanilac	R. K. Hart	x	x	x
48.	Shiawassee	C. L. Weston	x	x	x
49.	St. Clair	Geo. Waters	x	x	x
50.	St. Joseph	R. A. Springer	x	x	x
51.	Tuscola	John C. Shoemaker	x	x	x
52.	Van Buren	Wm. R. Young	x	x	x
53.	Washtenaw	R. N. DeJong	x	x	x
		J. S. DeTar	x	x	x
54.	Wayne	W. D. Barrett	x	x	x
		G. L. McClellan	x	x	x
		S. W. Insley	x	x	x
		R. L. Novy	x	x	x
		A. E. Catherwood	x	x	x
		H. F. Dibble	x	x	x
		L. W. Hull	x	x	x
		T. K. Gruber	x	x	x
		R. H. Pino	x	x	–
		H. A. Luce	x	x	x
		D. C. Beaver	x	x	x
		F. G. Buesser	x	x	x
		W. H. Honor	x	x	–
		R. C. Jamieson	x	x	x
		R. V. Walker	x	x	x
		L. J. Morand	x	x	x
		W. W. Babcock	x	x	x
		W. B. Harm	x	x	–
		L. J. Bailey	x	x	x
		W. S. Reveno	x	x	x
		C. F. Brunk	x	x	x
		M. A. Darling	x	x	–
		C. K. Hasley	x	x	x
		C. E. Simpson	x	x	x
		B. H. Douglas	x	x	x
		E. G. Krieg	x	x	x
		Arch Walls	x	x	x
		T. G. Amos	x	x	x
		V. N. Butler	x	x	x
		A. F. Jennings	x	x	x
		R. A. Johnson	x	x	x
		J. A. Kasper	x	x	x
		H. L. Clark	x	x	–
		C. S. Ratigan	x	x	x
		Duncan Campbell	x	x	x
		W. S. Gonne	x	x	x
		F. A. Weiser	x	x	–
		J. E. Cole	x	x	x
		R. C. Connelly	x	x	x
		J. H. Andries	x	x	–
		S. E. Gould	x	x	x
55.	Wexford	W. J. Smith	x	x	x
56.	Speaker	P. L. Ledwidge	x	x	x
57.	Secretary	L. Fernald Foster	x	x	x
58.	Immediate Past President	H. H. Cummings	x	x	x

J. J. O'MEARA M. D.: Mr. Speaker, I hold here in my hand, the credentials of 100 members who are delegates to the Michigan State Medical Society, 50 per cent of whom are not from any one county.

I hereby declare this session in order.

THE SPEAKER: If there are no objections to the Credentials Committee's report, we will consider it the roll call for this meeting.

Now, there is a question before the House to decide before we can proceed with our regular work. There is a question about whether or not one delegate can be seated. That involves another matter which shall be discussed later in the meeting. I will ask Dr. Foster to read now a petition which has been presented by the Council and as soon as that has been read and explained, then the House will take action on the possible seating of this delegate.

SECRETARY FOSTER: Mr. Speaker and Members of the House. This petition is being read and presented for action later. It is a petition of the Chairman of the Council to the House of Delegates, September 24, 1944.

VII—1. SEATING OF A DELEGATE

Petition re: Chippewa-Mackinac County Medical Society

At the meeting of The Council of the Michigan State Medical Society held today, September 25, 1944, The Council, with the affirmative vote of two-thirds of all the members thereof, adopted a Resolution that it recommend to the House of Delegates of the Michigan State Medical Society that the charter of the Chippewa-Mackinac County Medical Society be revoked, inasmuch as The Council feels that this County Medical Society has conducted itself in such a manner as to make such revocation desirable in the best interests of this Society. This action was taken in accordance with Chapter 1, Section 2 of the MSMS By-laws (Page 87 of the Handbook for Delegates).

The Council further recommends to the House of Delegates that any representative of the Chippewa-Mackinac County Medical Society who may present himself to be seated as a Delegate in the 1944 House of Delegates of the Michigan State Medical Society *be not seated,* as The Council feels, basing its opinion on exhaustive investigation made by the MSMS Ethics Committee, that a question exists concerning the legality of the election of *any* Delegate to the MSMS House of Delegates from this County Medical Society.

Therefore, in conformance with the By-laws, it is my duty to file with the Secretary of the Michigan State Medical Society this written petition signed by me, as Chairman of The Council.

Respectfully submitted,
V. M. MOORE, M.D.
Chairman of The Council
Michigan State Medical Society

SECRETARY FOSTER: The Speaker has asked me to give you a very short résumé of the situation in this particular component county society.

For a number of years, a condition has existed in the society that finally culminated in a charge of unethical conduct against some of the members, resulting in the expulsion of three of its members. These members, by their prerogative of state society membership appealed to the Councilor and to the Council. The Council referred the matter to its fact-finding Committee on Ethics which has held a hearing and made an exhaustive study of the charges involved in the conduct of these members. It made its recommendation and its report back to the Council at its midsummer meeting.

In view of the lack of evidence on some of the charges, the Council at its July meeting took action to the effect that the charges were not sufficiently substantiated to warrant the type of action taken by this Society and the Council further directed that a meeting of this Society should be held in September of this year to be conducted by the Councilor of the Twelfth District who should conduct the meeting with a view toward a reorganization of this group. A quorum, or a majority of the members in good standing as of December, 1943, was not present, and as a result, no meeting was held.

The action of the Council today is in line with that action taken in July, at which time the Council decided that the election of officers in that component county society raised a question of legality of election and as such, the Council refused to accept officially, the election of the slate of officers as presented.

It was the feeling of the Council, therefore, that no organization existed insofar as their recognition of their officers was concerned. Therefore, it was felt that if that were true and if the conditions in that county have reached a stalemate, which they apparently have, they could not justify the seating of a delegate from the Society whose election they had not approved.

I give you that background so you will understand the reason for the presentation to this body of this petition to be acted on later.

THE SPEAKER: Thank you, Dr. Foster. If you will please turn now to page 87 of your Handbook, the By-laws, Chapter 1, Section 2, you will find the section under which this action has been recommended. You may consider the statement made by Dr. Foster; the petition being read and the explanation given, as notices of hearing. This hearing will be held at our session tomorrow evening, after all of these things that Dr. Foster has mentioned briefly will be gone into detail. After that is done, if the House feels that it is then ready to take action on this matter, you will have a chance to do so.

Now, at this time, I would like to present the petition of B. T. Montgomery, M.D., of the Chippewa-Mackinac Medical Society. Dr. Montgomery is here with credentials signed by his County Secretary. Under the circumstances he cannot speak for himself and it is my privilege to speak for him. He petitions he be seated and it is up to the House of Delegates to seat him or not, as they see fit. He represents Chippewa County where this trouble is going on.

Are you ready for the question? All in favor of seating Dr. Montgomery, please stand—.

L. G. CHRISTIAN, M.D. (Ingham): I know nothing of this, but it seems to me that an indictment has been brought in.

THE SPEAKER: Dr. Christian, if you don't mind, I don't believe this is discussable. I think it is a question for each man to decide for himself.

DR. CHRISTIAN: There is no motion on the floor. If there is a motion made, I think we can discuss it.

Will you read Dr. Montgomery's reply before we vote? Isn't that fair?

THE SPEAKER: Dr. Montgomery has no reply. This is simply his credentials from the Secretary of his County Society.

DR. CHRISTIAN: It may be out of order, but it seems to me this is very irregular. If you are asking the House to decide on the competence of this man to be seated, we ought to hear him. We ought to know what these charges are. We have only heard a little. I know nothing about it, but it seems to me it is a little bit out of order.

THE SPEAKER: May I explain that? We haven't the time to go into long discussions. Now, you have heard the explanation. There is trouble up there and it was presented by the Ethics Committee and it, after a thorough investigation, recommends that this society is not in good standing and that has been sustained by the MSMS Council. Now, it is a question of whether this man is to be seated. It is a question of whether the House of Delegates wants to seat him or not. I think it is a question of yes or no, at this time.

DR. CHRISTIAN: Again may I say, the Council has all the evidence. We have none. Why doesn't the Council decide? We have no evidence. This is a serious thing. You are voting out ten, twenty, or forty members.

THE SPEAKER: Dr. Christian, you don't understand. You didn't listen. This question being decided tonight is only a question of whether or not to seat Dr. Montgomery in the interim. The other question will not be discussed until tomorrow night as I told you. The detail will be entirely different. This is merely a question of whether or not to give Dr. Montgomery the privilege of being seated.

DR. CHRISTIAN: May I rise to a point of order, then? May I ask the Secretary to read the question of who shall be seated in this House and when he shall be seated?

THE SPEAKER: It is left to the Credentials Committee and the Credentials Committee does not want to take the responsibility without the consent of the House.

DR. CHRISTIAN: May I request the Credentials Committee to come forward? I want to ask them a question.

THE SPEAKER: You can ask them a question if you want to. I think I can answer the question.

DR. CHRISTIAN: I want the Chairman of the Credentials Committee. I know nothing about the controversy, but I want to see this done right. This is a serious charge. The county medical society has sent their delegate here.

R. L. NOVY, M.D. (Detroit): There still is a Chippewa Society, isn't there, at the present time?

THE SPEAKER: It is not recognized.

DR. NOVY: There is a County Society unless the House does not recognize it?

THE SPEAKER: It is merely a question of seating the delegate.

Section 4. "The officers of county societies shall certify to the State Secretary the names of the delegates and alternates who shall represent them at the Annual Meeting."

Now then, there has been very good reason to believe, Dr. Christian, after thorough study by our Ethics Committee, that there were irregularities in the meeting up there.

DR. CHRISTIAN: Please understand me. I merely want to bring it before the floor of the House to see what the things are.

THE SPEAKER: Then, the Chairman will entertain a motion to seat the delegate.

DR. CHRISTIAN: I move that the delegate from Chippewa County be referred to a special committee of this House to report tomorrow morning.

THE SPEAKER: The Chair doesn't wish to accept that motion. He asked for a motion to seat the delegate. We can't discuss other things.

DR. CHRISTIAN: I can't do that because the information is not forthcoming. Again may I say to the delegates that I know nothing about this, but I do not believe any county medical society should be denied a voice on this floor unless we know about it, and I have asked for the Chairman of the Credentials Committee for the cause. With that, I will sit down.

S. L. LOUPEE, M.D. (Cass): Did not the Secretary state that this whole matter would be brought before the House of Delegates tomorrow evening?

THE SPEAKER: That is correct.

DR. LOUPEE: Does this motion provide we shall vote to settle the seating of the delegate from Chippewa temporarily until tomorrow evening or permanently?

THE SPEAKER: I think it would have to be permanently for this meeting.

DR. LOUPEE: How are we going to vote to seat him permanently until we know the action of this group tomorrow evening?

THE SPEAKER: Until the group has taken action, I will accept that motion. The Chairman will accept the motion to seat the delegate from Chippewa County until such time as the House of Delegates has passed sentence.

R. L. WADE, M.D. (Branch): Suppose you find that this society is guilty of some misdemeanor and that we would not approve of their actions? Then, we would have to expel this member whom we elect tonight. That is not fair.

THE SPEAKER: Not necessarily. You don't have to take any action on that. The only question before the House is, Whether or not to seat this delegate until such time as the House determines what to do with the County Society. That is all there is to it.

T. K. GRUBER, M.D. (Wayne): May I ask if the Charter of this Society has been revoked by the Council?

THE SPEAKER: Oh no, the Council hasn't the authority to revoke that.

Just a moment. Let me tell you what has been done. The Council has petitioned the House of Delegates to revoke the charter and we cannot take action on that at this time because there are too many things coming up first. We would have our whole meeting spent on it.

DR. GRUBER: In reading Section 6, pages 95 and 96, it says, "It shall upon application provide and issue charters to county societies organized in conformity with this Constitution and By-laws and revoke such charters when deemed necessary." There is no reference to the House of Delegates at all.

THE SPEAKER: If you will look on page 87, Chapter 1, Section 2 of the By-laws you will see that the method the Council has of doing that is by recommending it through the House of Delegates.

DR. GRUBER: From reading the two, I think it would be well if the By-laws—the two sections—were brought into conformity. One says the House of Delegates shall, and the other says the Council shall.

THE SPEAKER: You are out of order for the time being. Are you ready for the question?

(The question was called for.)

THE SPEAKER: All in favor of having Dr. Montgomery seated until such time as the House shall determine the status of his society, say "aye"; contrary "no." Dr. Montgomery is seated and will the Credentials Committee see he has the proper introduction?

S. L. LOUPEE, M.D.: Since this matter is up for discussion, I would like to know whether any special study is going to be made of that very important question between now and tomorrow evening.

THE SPEAKER: That has been disposed of and we will go on with the regular order of business. I will answer your question later.

The next thing is the appointment of committees. First, we will appoint the Press Committee. We are glad at this time to welcome the members of the press. The members of the press have been very kind to us in the past and we ask the same co-operation of them this year as they have given before, which is a definite request that they are not to publish anything unless it has gone through our Press Committee.

The Press Committee: Harry H. Dibble, M.D., Chairman, E. A. Oakes, M.D., L. F. Foster, M.D.

Now, the other committees will stand as on page 3 of your Handbook, with these exceptions: H. E. Hanson, M.D., on the Committee of Officers Reports, is not here. He will be replaced by B. G. Holtom, M.D., of Calhoun County. That is the same county.

W. E. Nesbitt, M.D., under Reports of Standing Committees, is not here. He will be replaced by F. J. O'Donnell, M.D., Alpena.

The committees will meet directly after the session tonight. They are meeting tonight in the rooms listed on the blackboard. The stenographers for these committees will be in the room directly in back of this one. Please do not ask them to go to other rooms to take work. They will be here tonight and tomorrow night, and will take care of anything you might have to do.

Now, Dr. Loupee, may I answer your question briefly? I thought I had explained that before, but I will explain it once more, because this is a very serious and delicate matter and I assure you, as far as the Speaker of the House of Delegates is concerned, these gentlemen will have the fairest kind of treatment. What we propose to do is this:

This will be handled, according to that section which we have already invited to your attention, but when this is taken up tomorrow night, all of this material will be reviewed. If, at the end of that review, and if after answering as many of your questions as we can, you are ready to take action on the problem, and think it has had sufficient study and are willing to take action on it at that time, you will be asked to vote. If the majority of the House of Delegates feel we are not ready to take action on it at that time, action will be delayed for a future meeting.

Does everybody understand that now? Do you agree that it is fair to those who are in trouble? That is the way we intend to handle it. Does that answer your question?

DR. LOUPEE: I want to commend you for ruling me out of order and proceeding with the business.

THE SPEAKER: Thank you.

The next order of business is the Speaker's address. The Vice Speaker will please take the Chair.

(E. A. Oakes, M.D., the Vice Speaker, assumed the Chair.)

THE CHAIRMAN: Mr. Speaker, I would like to say a few words, particularly to the newer delegates who haven't been seated in the House of Delegates before. The Speaker's address sets the keynote and tells us what we have to do, not only here in the House of Delegates, but largely what is planned for you. I commend your very active interest because Dr. Ledwidge always has something on the ball and he has something that is important to each one of us. I present the Speaker!

II. Speaker's Address

The Speaker's Address will be confined to a progress report on the Emergency Maternity Infant Care Program in Michigan.

The Michigan State Medical Society House of Delegates, on Sept. 21, 1943, passed two motions on this subject as follows:

(1) "Because this plan is a form of state medicine, the Michigan State Medical Society refuses to cooperate in any of the provisions of the plan in the present form."

(2) "Until satisfactory adjustments in the plan can be made the members of the Michigan State Medical Society are requested to give medical care gratis, in order that the wives and children of servicemen may obtain hospital care."

Pursuant to the instruction implied in this second motion the Council, through its special EMIC Committee (Drs. Keyport, Foster, and Ledwidge) has continued to negotiate, but has accomplished little. In the process of these negotiations meetings have been held with the Auditor General of Michigan, with Michigan Medical Service, with the Michigan Department of Health, and two meetings with representatives of the U.S. Children's Bureau. The first of these two meetings was with Edmund F. Daily, M.D., of the Bureau, when he appeared before the full council, September 23, 1943; and the last was with Martha M. Eliot, M. D., Assistant Chief of the Children's Bureau and Peter Seitz of the Solicitor's Office attached to the Bureau, June 8, 1944.

By February it became fairly evident that "satisfactory adjustments" were not to be made, and under instruction of the Executive Committee of the Council the "Secretary's Letter" carried the following advice to our loyal members: "So far as the State Medical Society is concerned, physicians may properly:

(A) Sign the blanks to provide for hospital service, giving professional care gratis; or

(B) Sign the blanks and accept the government fee for medical care; or

(C) Decline to participate in the program, as they see fit."

Three requests for major changes in the method of administration of the program have been made. All three have been refused by the United States Children's Bureau.

Request number one was that recipients of service under the program, who so desire, might have their hospital expense paid and be permitted to obtain medical care from their own private physicians on a fee basis. You will recall that this request was rejected by a telegram to Dr. Moyer which was read to this body during our 1943 session.

The second request, namely, that allotments for the EMIC program be made direct to the serviceman's wife and dependents, is one that has been made by the American Medical Association House of Delegates, by several state medical societies, and by other professional groups. It has been turned down on the grounds that it is contrary to the intent of Congress and therefore cannot be put into effect without congressional action. Just how far the intent of Congress has been influenced by the Children's Bureau is difficult to ascertain. The facts seem to be these. The trial balloon for the EMIC program was carried out in the State of Washington in 1942. In this project the Chief of the Children's Bureau used funds that were then available to her department and certainly had complete descretionary power. From March, 1943, to September, 1943, inclusive, Congress passed three separate bills appropriating funds for the EMIC program. None of these bills specifically states how the money shall be paid, and it is reasonable to assume that in the beginning considerable descretionary power in this regard was left with the Chief of the Children's Bureau. At any rate the program calling for payment direct to physicians was set up, as you know. Congress, in making its second EMIC appropriation in July, 1943, did not criticize this method of payment, which was interpreted by the Bureau as approval. When the third appropriation bill was before Congress in September, 1943, an amendment calling for allotment was offered and was defeated in the House of Representatives. Hence, the conclusion that congressional action would be required to make the change at this time seems justified, but the responsibility of the Chief of the Children's Bureau in thus setting up the program cannot be denied.

That Doctors of Medicine in this state, who so desire, be paid through Michigan Medical Service was the third request. This possibility was first discussed September 23, 1943, with Dr. Edmund F. Daily of the Children's Bureau, who invited us to submit a plan. The Michigan State Medical Society membership was polled on this matter in October, and those who answered expressed a preference for payment through Michigan Medical Service by a vote of six to one. A plan was then worked out but was rejected by the Children's Bureau in February. Having the approval of Michigan State Medical -Society, Michigan Medical Service, Michigan Department of Health, and the Auditor General of Michigan, the plan, with certain refinements, was resubmitted through the Assistant Chief of the Children's Bureau at our June 8 meeting. Notice of its second rejection was given by telegram from the Chief of the Children's Bureau to William DeKleine, M.D., Michigan Commissioner of Health, under date of September 14, 1944. The reason previously given for its rejection was that the Solicitor could find no precedent for assigning a federal administrative duty to a private agency. This seemed to us a silly ruling in view of the fact that Michigan Medical Service is a nonprofit service organization, and especially in view of the fact that the whole EMIC program had been set up without precedent. This latter ruling is not a matter of great importance except as it reflects the attitude of the Children's Bureau to the Medical profession. This attitude is reminiscent of, and perhaps best exemplified by a notice once seen posted in a service garage which read, "Please do not be afraid to ask for credit, our refusal will be courteous." Suggestions from our group are solicited but usually are not followed by the Bureau.

The Bureau has made some concessions that directly affect our membership. I shall enumerate them:

1. The Medical Advisory Committee to the Chief of the Children's Bureau has been enlarged to include five general practitioners. The members of this committee are invited by the U. S. Secretary of Labor and are called together from time to time by the Chief of the Children's Bureau to act in an advisory capacity only. It has previously been made up of specialists, teachers, and institutional men, many of whom are not engaged in the practice of medicine.

2. As of February 1, 1944, the fee schedule in Michigan was increased.

3. Our suggestion as to the method of selecting consultants in the program apparently has been accepted. This insures each of our members the right to qualify

as a consultant and makes him eligible to receive the consultation fee if and when he is called as a consultant.

The following data relevant to the EMIC program are interesting:

1. The case load in Michigan is averaging from 1,000 to 1,800 per month. The highest figures were reached in June, July and August of this year. The total number of applications up to September first was 19,742, of which 1,302 were pediatric.

2. Now co-operating in the Michigan plan are 1,988 Doctors of Medicine and 344 osteopaths. Under a Children's Bureau ruling the osteopaths are limited to obstetric care only. The 3444 osteopaths have made 1,276 maternity applications.

3. Effective February 1, 1944, a new schedule of fees was established as follows: Up to $15.00 for prenatal care, $35.00 for delivery with six weeks subsequent care of mother and two weeks care of infant, and $5.00 for postpartem examination six weeks after delivery; for pediatric care $3.00 per house call and $2.00 per office call limited to a total of $24.00 without further authorization; for consultation a maximum fee of $10.00 is allowed.

4. Hospitals are now paid fees to cover their individual per diem cost.

5. As of June 1, 1944, the over-all EMIC federal case load was running about 40,000 per month.

6. There was available for this program for the fiscal year ending June 30, 1944, $29,700,000. For the fiscal year beginning July 1, 1944, Congress has appropriated $42,800,000 of which not more than 2 per cent may be used for administrative purposes.

The EMIC program has not been a total loss to our Society. It has demonstrated once more that the Doctor of Medicine in private practice recognizes and accepts his responsibilities and will take care of his people even though the going is tough and the circumstances distasteful. In the last analysis it has served to create a beter understanding between the Michigan State Medical Society and the Michigan Department of Health. Our dealings with that department in the past year have been most cordial. Lastly, it has taught us, or should have taught us, something of the fallacies of federalized medicine in general, and of its administration by the U. S. Children's Bureau in particular. In this connection we have been assured that the EMIC program is in truth an emergency measure that will terminate six months after the war's end, but we have very good reason to suspect that further legislation along similar lines is in the offing.

Two statements by Martha M. Eliot, M.D., Assistant Chief of the Children's Bureau are pertinent. When in conversation with Dr. Eliot, Dr. W. W. Bauer of the American Medical Association remarked: "The doctors would be better satisfied to co-operate in this plan if they could be assured that it is not the opening wedge for broader plans." Dr. Eliot is said to have replied, "I dont' think they can be given any such assurance." At our June 8 meeting the question of the possibility of the EMIC being extended into the postwar period was raised. Dr. Eliot stated that this program was authorized by special emergency legislation and would not be extended into the postwar period. Then added, "Any future legislation will have to be very carefully written." While Dr. Eliot is to be commended for her forthright frankness, the implication as to future legislation is clear.

Well, what should we do about it. Your Speaker does not pretend to know the answer, but respectfully submits these suggestions for your consideration:

1. That for the present we continue with each individual Doctor of Medicine exercising his right to accept the government fee, to take care of the serviceman's wife and dependent gratis, or to decline to participate in this program as he sees fit.

2. That we, individually and as a group, help the U. S. Children's Bureau to keep its promise to terminate the EMIC program six months after the end of the present war, by not co-operating in the program after that date; and, that this expiration date be called to the attention of our membership through the then current "Secretary's Letter."

3. That in keeping with the "Declaration of Medical Policies" adopted by this House of Delegates last year, we flatly refuse to participate in any future health program that is inaugurated without first having been submitted to our Society for study and approval.

4. That if and when such plans are submitted to us for study, we study them with a tolerance and fairness becoming to our profession.

THE CHAIRMAN: Thank you, Dr. Ledwidge. The Speaker's address will be referred to the Committee on Officers' Reports. I will turn the Chair back to the Speaker.

(The Speaker reassumed the Chair.)

THE SPEAKER: Our next order of business is the President's address by President C. R. Keyport, M.D.

III. President's Address

One year ago, when I was inducted into the office of president of this association. I said, "To serve as president of the MSMS is a distinct honor. It is with genuine appreciation of this privilege and responsibility that I pledge my efforts to maintain our program of democratic medicine and to urge that your participation and co-operation be steady and enduring."

During this past year, I have enjoyed the highest honor which the Michigan State Medical Society can bestow, the presidency of this organization. I have watched with great interest, the growth of united solidarity in our profession. I have been deeply impressed by the willingness and sincerity of fellow workers who shouldered responsibility and gave me competent aid in the administration of this society. I shall never cease to be profoundly grateful for the distinct values which have accrued to me through this generous and loyal association. I feel that the MSMS as an organization is one of the finest examples of an unbiased and co-operative group that can be found any place in the world.

It is understandable, however, during the past year that some of you may have felt my leadership has over-stressed the economic side of medicine. Through THE JOURNAL, I have insistently called attention to the economic problems of medicine. In nearly every issue, I have emphasized solutions needed and have laid particular stress upon immediate action in that direction.

These are times of national unrest and world conflict. If we are going to preserve our democratic principles, particularly in reference to giving the people of this state and these United States the finest medical service in the world, making it available to all the people, then, I feel we must do so by considering the economic side of medicine.

I regret that each and every one of you cannot be a member of the Council or the Executive Committee of the Council. It is a revelation to sit in these meetings and see the careful, thoughtful deliberations of these men. The chairman of the Council has a tremendous amount of work to do, and Dr. Vernor M. Moore deserves a sincere vote of appreciation from this House of Delegates.

In Dr. L. Fernald Foster as secretary, and Bill Burns as executive secretary, MSMS can boast of the best secretarial combination of any society in these United States.

Dr. Wilfrid Haughey and his publications committee of the Council have been responsible for THE JOURNAL,

and each and every one of you can attest to the excellence of this publication and be justly proud of it.

As long as Dr. William A. Hyland is treasurer of this Society, you can rest assured that financially MSMS has nothing to worry about.

To the various committees of the State Society, I can only say that you have been grand during this past year, and the many accomplishments mark additional pages of fine achievement in the history of the Michigan State Medical Society.

During the past year, we have had numerous problems to consider. You will recall that during the meeting of the House of Delegates last year, we were most concerned with the EMIC Program, and this body, the House of Delegates, referred the matter to the Council. The Council then referred this matter to a special committee of which Dr. Ledwidge was chairman. Many meetings of this committee were held with State and Federal agencies, and regardless of the untiring efforts of Dr. Ledwidge and his committee, there has been no change in the administration of this program. Let us hope that in the immediate future, we will be better able to combat this vicious type of federal legislation in its inception, and curb the autocratic rule of bureaucrats who seemingly are not responsible to any legislative controls.

During the meeting of the Council in July of 1943, there was formed the Michigan Health Council. The groups comprising the Michigan Health Council were the Michigan State Medical Society, the Michigan Hospital Association, Michigan Medical Service and Michigan Hospital Service. This council was created to act as a clearing house for all four organizations on matters of mutual interest, so as to keep all organizations informed of the program and actions of the others, to enable all the organizations to present a united front on matters of common interest and to prevent conflicts which might affect two or more of these organizations.

This Michigan Health Council was a little slow in getting started but it is now well established and the recent economic survey made in Michigan under the direction of the Michigan Health Council will be presented to you during this meeting. I am confident this survey will be of real value to each and every one of you.

One of the undertakings of the Michigan State Medical Society in the past few years, and the one that has caused many headaches, and also many personal controversies, has been our own program of providing a means whereby the people of Michigan could obtain adequate medical care. This program envisions medical care geared to the economic status of the people, and makes provision for budgeting against catastrophic illness. I speak of Michigan Medical Service. I am happy today to announce that Michigan Medical Service is rapidly becoming solvent; it is meeting a much-needed demand and is going to continue to advance and bring added benefits to its policyholders. All this is a glowing tribute to the officers, the board of directors and the individual doctors of the State of Michigan.

During the past year I have continually stressed the necessity of the economic side of medicine and the need for better controlled and integrated public relations. In the past we have been too prone to delegate all matters dealing with legislation as they affect us to our legislative committee. The legislative committee is composed of Doctors of Medicine. They are not legislators or politicians. They are too much engrossed in the practice of medicine to devote much of their time to matters of legislation. It should not be expected or requested of medical men.

What we need is a full-time public relations man. There is no more important group in this state than the doctors. If the public utilities, the railroads, the chain stores and a host of other groups can have a full-time public relations man why not the medical profession?

What I mean by a public relations man is not an individual who plays around our State Capitol trying at the last minute to block some bill which we think is bad for medicine and public health; but a public relations man who can during the entire year so carry on a program of public relations in every representative district so that when legislative acts are proposed which tend to lower health standards or are going to change the picture of the practice of medicine as we know it we will not be caught with our fences down.

For example, at this very moment there has been prepared one of the most drastic proposals in the shape of an amendmment to the constitution of the State of Michigan. If the people vote favorably for such an amendment it would make the Murray-Wagner-Dingell Bill look like small peanuts in this state.

Fully confident of your approval I can now disclose to you that at the midsummer meeting of the Council the Executive Committee was authorized to proceed to employ a public relations man. A committee is at present endeavoring to find the best possible man in Michigan for this most important job, and when he is secured, he should not be an undercover man, but should be definitely known as the public relations representative of the physicians of Michigan.

Last year, this House of Delegates voted an assessment of $10.00 per member to carry on an educational program. During this meeting you will be appraised of the monies expended for this work. While there may be a balance on hand, the whole amount has been allocated; I sincerely hope that this House of Delegates will vote to continue this assessment this coming year and for as many years as future needs demand. You need to protect yourselves during this critical era.

Through the generosity of the late Andrew S. Biddle, who at the time of his death was our oldest Past President, the Michigan State Medical Society Foundation for Postgraduate Medical Education has been further endowed. This marks the beginning of a *live* endowment fund. The noble example of Dr. Biddle should be followed by many other doctors of medicine who have been privileged to reap the rewards of a grand profession. The opportunity and privilege of contributing to the Foundation for Postgraduate Medical Education is yours, now.

As I relinquish the presidency of this Society to the president-elect, Dr. Andrew S. Brunk, I hope that your unlimited support will continue during his administration. Your unfaltering loyalty and alert cognizance of forward procedures in the years to come will enable the MSMS to continue to hold the respect of the people of this state, and at the same time, to administer the best medical services in the world to the people of Michigan.

THE SPEAKER: This report will be referred to the Committee on Officers' Reports.

I wish now to make one announcement which I should have made earlier. There is one change in reference to the committees. On the Reports of Special Committees, W. H. Honor, M.D. (Wayne), who has not been well for the last few days, will be replaced by Frank A. Weiser, M.D., also of Wayne County.

It is a pleasure now to call on our President-Elect, Andrew S. Brunk, M.D.

IV. President-Elect's Address

Principles worth while must be fought for, to be preserved. Today we are fighting a World War to uphold and maintain a great principle: freedom under democracy. It is a costly fight, bringing sorrow and misery, but it is a worthy one. When the battle ends and victory is ours, a great principle shall have been preserved to us but especially to our posterity.

During the stresses of this wartime period strong winds of social change are blowing. Straws in that wind would indicate that Medicine will not be untouched in the evolutionary metamorphosis resulting from the

present global struggle. We might mention but three of these many straws to illustrate: (a) the Wagner-Murray-Dingell Bill, (b) the autocratic rule of the U. S. Children's Bureau in the EMIC Program, (c) the proposed "State Medicine" amendment to Michigan's Constitution.

Medicine has great principles, developed throughout the years, in the interests of those whom we serve, our patients. Under these principles Medicine in these United States has achieved the highest scientific attainments in the world. The best medical care anywhere at any time is attainable in this country under the present system of time-tried, private medical practice. Some Utopian sociologists, aided by some very practical politicians in this country, would change these principles upon which Medicine is founded—in fact they would throw away all vestige of the present principles and substitute in their stead the dictum of compulsory rule which experience has shown would lower the present high standards. Despite their greatness in numbers and power these enemies of a great science must be stopped. The great principles behind medicine must be fought for to be preserved. A practical plan must be outlined to show the people what they will lose if they listen to the false chant of certain politicians and sociologists (including unfortunately a number of our own brothers) who have much to gain personally from public acceptance of their ideaology.

It is time for us doctors to awake, and know what is going on about us. Realize the attacks being made upon us and our profession. They are real. They are powerful.

You delegates from every county medical society of Michigan are the natural leaders in your communities. Aided by the officers of your county societies, you must spread your knowledge to every Doctor of Medicine in your organization. He in turn must tell the people the facts—the truth. It is the people who will decide the issue, and SOON. There is no time to lose. Our principles are being attacked today; if we would maintain a great principle—medical freedom under democracy—we must join the fight now. It may prove to be a costly fight, but, Gentlemen, it will be a worthy one. We shall be fighting for a great principle which shall have been preserved not alone to us but to those who follow us in Medicine.

Therefore, during my brief tenure of office, I pledge that I shall support enthusiastically an acceleration of a program of greater information to the people. The history and accomplishments of Medicine must be told. The work that Doctors of Medicine are doing—both at home and in military service—must be stressed. Our citizens must be impressed with this truism: that only a free science, unchained and untrammeled, can soar to greater heights.

Further, I pledge that every effort will be made to bring proper information to those men and women who make the laws affecting you and your practice, to the end that health legislation, which in Michigan has been of high type in recent years, is not tampered with or destroyed.

Third, with the help and approval of the practitioners of Michigan, that facilities and programs supplemental to medical practice, will be instituted or maintained where necessary. As an example, Michigan Medical Service, our group medical care plan, must be mentioned with pride. This your-year old supplement to medical practice has proved to be a successful experiment—the best in the country—and a bulwark against threats of federalized and state schemes of compulsory medical practice. With its flaws, Michigan Medical Service is to be preferred to some nebulous scheme of dreamers or schemers. Michigan Medical Service supplements, in a fiscal manner, medical practice. It is not a substitute. It does not change the principles of Medicine. I repeat, Gentlemen, it is to be preferred, because it is our plan.

Fourth, I pledge that every effort will be made to enlist the support of other persons, groups and organizations, that will aid Medicine to preserve its principles. Specifically, let me mention one organization which had its beginning as recent as July, 1943; The Michigan Health Council. This association of representatives of the Michigan Hospital Association, Michigan Hospital Service, Michigan Medical Service, and the Michigan State Medical Society, is a vehicle whereby these organizations can co-ordinate their efforts in arranging for the availability of medical, hospital and related services, and informing the public through a general educational program what these organizations are doing to meet the health needs of all people in the state. The program of The Council will be based upon facts gathered from the people themselves through a survey of public opinion—the premier release of this poll to be presented in this room, next Thursday evening, September 28, at the evening General Assembly. The Michigan Health Council should be a great force for good in this state. Its information to the public will be based on facts, without bias. This Council and all similar organizations must be told of the attack on Medicine, and their co-operation must be enlisted to help in our fight. They *must* help us, because their interest is the people's interest, and our battle to preserve Medicine's principles is also in the people's interest.

Let me conclude by thanking all of you, for the whole hearted co-operation, which I am sure I will receive. I need your support to make the 1944-45 program a success.

THE SPEAKER: The President-Elect's address will be referred to the Committee on Officers' Reports.

V. W. Moore, M.D., Chairman of the Council will present the Annual Report of the Council at this time.

V. Annual Report of the Council

SUPPLEMENTAL REPORT OF THE COUNCIL, MSMS

September 25, 1944

The Annual Report of The Council for the year 1943-44 appears in the Delegates' Handbook beginning at page 34. As this report was written in July in order that it might appear in print, The Council wishes to submit additional information on matters which it has considered during the past two months:

1. *Revision of By-laws.*—The Council referred two proposed revisions of the By-laws to its Special Committee on Constitution and By-laws, C. L. Hess, M.D., Chairman. This committee considered amendments re (a) special membership for members incapacitated due to military service, and (b) ethics, and reported to The Council in July. The Council, after studying the proposals for a considerable length of time, received the first amendment and referred it to the 1944 House of Delegates; it re-referred the proposed Ethics Committee amendments back to the Special Committee which again reported on this matter to the Executive Committee of The Council on August 24. The Executive Committee received the final report and requested the Special Committee to present its recommendations to the House of Delegates on Septembr 25, 1944.

2. *Declaration of Medical Policies.*—In September, a second printing of the "Declaration," together with a Pledge to be signed by every MSMS member, was mailed to the entire membership. The Council of the State Society needs the tangible support and "backing" of every member of the Michigan medical profession. A return of 4,000 or more Pledges will represent vast support and show the strength and unity which exists in the ranks of the medical practitioners in this State. The total number of Pledges signed and returned to the Society, by September 22, were 1,005.

3. *"We Need a Book."*—A treatise containing Facts and Fancies about Medicine, for public consumption, is vitally needed. The Council appointed a Special Com-

mittee which reported that a permanent, attractive book should be prepared, well illustrated and written by a professional author who obtains his facts from the Michigan State Medical Society and other organizations involved; further that this book should be thoroughly distributed to the public, but be of such a format that it is salable. The preparation of such a book is now being considered.

4. *Proposed amendment to Constitution of Michigan.*—A petition proposing an amendment to the Constitution of the State of Michigan, *which would include a system of compulsory sickness insurance,* was presented to the Michigan Secretary of State in June, 1944. A committee of the State Medical Society has been appointed to work out a detailed program so that information concerning the weaknesses of such a revolutionary proposal can be brought to the people, should this proposal be placed before the people for their vote next spring. If such a monstrosity *is* presented, it will require the concerted and sustained efforts of every individual member of the medical profession to help defeat this scheme which outdoes the Wagner-Murray-Dingell proposal. If sufficient signatures are presented to the Secretary of State, the medical profession of Michigan *can look forward* to the most bitter, time-consuming, and costly battle of—and for—its present existence.

5. *Public Relations Activity.*—A full-time public relations counsel and a permanent, sustained program of information, first, to the profession and, second to the people is necessary *now.* Every member of the profession must know what social, economic and political issues are facing him: and more important, what are his responsibilities in solving these problems. County medical societies and their individual members must enlist support back home—the most powerful contacts being in the doctor's own home town. The stimulus for this necessary, vital public relations program will come from the full-time services of a man trained in public relations work. The Council has voted to employ such a specialist and to create this new department.

6. *Public Education Account.*—This fund, accumulated from the special $10.00 assessment levied by the 1943 House of Delegates, has been kept separate from the other funds and accounts of the Society and has been used exclusively for public educational purposes, as indicated by the following accounting (up to September 22):

PUBLIC EDUCATION FUND
FINANCIAL REPORT
To September 22, 1944

School of Information (1/30/44)	$ 3,059.71
Purchase of Pamphlets	1,329.92
Michigan Health Council	5,000.00
Radio Program	10,001.80
Publicizing Radio Program	500.17
Miscellaneous	9.70
	$19,901.30

The unspent balance is already allocated for the same and similar public education activities.

Concerning the *ordinary* funds of the State Society: the remission of dues of 1,151 members now in military service has meant a loss in annual revenue of over $11,000. Despite this shrinkage of income, the activities of the Society have not been curtailed; in fact, the threat of the Wagner-Murray-Dingell Bill, the proposed amendment to the Constitution of Michigan, and similar revolutionary proposals have forced added work on the State Society and its Executive Office, as has been the experience of every other live state medical society (with which we are in constant touch and working in harmony). We may be forced to draw upon our reserves to a limited extent, but due to the good business management of the Society, this will not be great.

7. *Michigan Health Council.*—The sponsors of the Michigan Health Council, as will be remembered, are the Michigan State Medical Society, the Michigan Hospital Association, Michigan Medical Service, and Michigan Hospital Service. The first two organizations are represented on the Health Council by three members each; the two pre-payment plans each have representation by two members.

Thus far, the Health Council has been supported financially by contributions of $5,000 each from the Michigan State Medical Society and Michigan Medical Service, with an equal amount from the two hospital organizations. Total contributions thus amount to $20,000. Of this amount, some $9,000 is set aside as the expense of the survey of public opinion, and disbursements have amounted to $3,038.63 as of September 12. Slightly more than half of the disbursements have covered fees and travel expenses connected with public addresses sponsored by the Health Council and the balance has gone into salaries, office rent, and incidental expenses. The unexpended balance on September 12, 1944, amounted to $7,842.91.

What the Michigan Health Council has sought is a constructive program of mutual benefit to the medical profession, the hospitals and the public. We feel that the projects we have undertaken to date should be of definite help toward the realization of that program.

8. *Problem of Ethics.*—The Ethics Committee report (page 48 of the Delegates' Handbook) indicates that it has had its troubles with one county medical society during the past year. The long-standing problem at the Soo finally resulted in a meeting ordered by The Council on September 8, and to be presided over by the Councilor of the 12th District, MSMS. No quorum was present.

A petition on this subject will be presented to the House of Delegates at this meeting.

9. *Brasie Resolution of 1943.*—A Special Committee (Sladek, Beck, Riley, Witwer) was appointed by The Council to study and report on this proposal to limit Michigan Medical Service to Doctors of Medicine.

If this Resolution were adopted, it would put Michigan Medical Service out of business. Michigan's successful program of group medical care cannot survive if such peremptory action is taken at this time. (The problem outlined in the Resolution was not created by Michigan Medical Service); it represents an ever-increasing growth over the years that is a *problem of Medicine, for the profession to solve.*) If you desire Michigan Medical Service, which is our only telling answer to federalization and regimentation, to continue as your bulwark, this Resolution should be tabled and in its place specific authority to test the legal rights of certain practitioners—the *test to be timed for the most propitious moment—should be granted The Council.*

10. *Bequest of the Biddles.*—The Late Dr. and Mrs. A. P. Biddle have remembered in a most generous way the Michigan State Medical Society. At the doctor's death (August 2, 1944) the Society was informed that proceeds from insurance policies, in the amount of approximately $15,725.00 and an additional $5,000 from the residue of Dr. Biddle's estate, were immediately payable to the MSMS Council, and that the Society also was a legatee (subject to a life interest, of the residue of the Grace W. Biddle Estate in the amount of approximately $21,000. In all, the total amount left to the MSMS by Dr. and Mrs. Biddle will approximate $42,000.

Several years ago, The Council created the Michigan State Medical Society Foundation for Postgraduate Medical Education and placed the first sum ($10,000) in this fund. Dr. Biddle's great contribution justifies the foresight of The Council. His extreme generosity should serve as a noble example that could be followed by other Doctors of Medicine and laymen interested in continuing medical education.

THE SPEAKER: This report of Dr. Moore's will be referred to the Reference Committee on Reports of the Council.

THE SPEAKER: Now, going on with the regular order of business, the Report of the House of Delegates of A.M.A., by Henry A. Luce, M.D.

VI. Report of Delegates to A.M.A.

HENRY A. LUCE, M.D.: If you will turn to page 44 of your Handbook, I will read the first paragraph:

"The regular delegates from Michigan were all present and took an active part in the proceedings of the 94th Annual Session of the American Medical Association held in Chicago, June 12 to 16, 1944. There are many delegates from other states who either are indifferent or take little interest in crucial matters affecting the organization. Many are out-and-out specialists and only manifest interest when their 'ox is gored.' Many have secured economic independence and have little interest in the general subject of economics as it affects the man in the 'sticks.' Others enjoy a ride on the bandwagon and, like puppets, perform when the 'old guard' pulls the string."

I have said once before that I have felt, and that it is my opinion, that there is more real knowledge of medical economics represented in the House of Delegates of the Michigan State Medical Society than there is in the American Medical Association's House of Delegates. There are many good men in the American Medical Association's House of Delegates, but there are a great many of them who fall into the classifications which I have just read to you.

The American Medical Association has done a great many commendable things. A great deal of scientific knowledge has been fostered. A great many projects of scientific nature have been nourished and nurtured, but to most of the men who practice medicine, they have felt that the House of Delegates or the Board of Trustees or the Officers of the American Medical Association have not been close enough to their problems. I will speak a little more of that later.

The resolution that was referred to the delegates from Michigan to be presented regarding the change of the American Medical Association from a scientific body into, as you might call it, a business league, was presented by Dr. Gruber and I want to give you a little more information on that later.

On page 46, you will notice two or three minor resolutions that were passed. The attitude of the profession regarding maternal and infant care, a resolution to transfer those activities of the Children's Bureau to the Public Health Service, was approved. On the other hand, a resolution to consolidate federal health activity in a single federal health department was disapproved. Very frequently, the House of Delegates will approve one thing and disapprove a similar thing.

Probably the most interesting point in the whole meeting was the report on a resolution that came from the state of California.

This is what is published in J.A.M.A.: "Dr. Dwight L. Wilbur of California presented by title, a resolution dealing with the Secretary of the American Medical Association which was referred to the Reference Committee in Executive Session."

Now, that reference committee made its report on the resolution concerning the Secretary of the American Medical Association, referred to it by title, something like this: Never before has American Medicine been so needful, as now, of unity. The desire to extend the high quality of medical service to all the people at a reasonable cost is the objective sought by all of us. Your committee is convinced this can be attained more certainly if physicians throughout the nation would give their loyalty and support to those selected by this House of Delegates as members of the House of Trustees and to the representatives selected by the Board itself.

The Reference Committee did not approve this resolution from the State of California.

In other words, the committee disapproved that resolution.

Before it went to ballot or before they asked to vote on it, the minutes carry the following statement:

"A vote by ballot was requested by Henry A. Luce, M.D., of Michigan, seconded by Walter B. Martin, M.D., of Virginia." This motion was laid on the table, so only nine registered a vote in favor of the California resolution.

I have asked the other members who are Dr. Christian, Dr. Gruber, Dr. Keyport, Dr. Reeder, to give you something further as a report. I will ask Dr. Keyport to give you something about the Wheeler Bill. I will ask Dr. Gruber to give you something about national activity and what provisions have been made for returning medical officers. I will ask Dr. Reeder to tell what other states are doing in regard to the maternal emergency care, and they will give that tomorrow as a supplemental report.

Now, Mr. Speaker, if you will call upon the other members of the delegation I shall conclude my report as chairman of the delegation.

THE SPEAKER: Thank you. Dr. Luce's report will be referred to the Committee on Officers' Reports.

VII. New Business

THE SPEAKER: It is now our privilege and pleasure to introduce one whom I shall call a friend. He is Ira Dean of Grand Rapids, president of the State Association of Welfare Boards.

VII—2. ADDRESS OF IRA DEAN

Mr. Speaker and Members of the Board of Delegates: I am more than pleased to be here tonight for two reasons: One is that we are happy to have you meet here in Grand Rapids, which we consider one of the best convention cities in the State of Michigan, and on behalf of the State Association of County Social Welfare Boards, I wish to thank you for the privilege of appearing before you and assuring you that we appreciate your co-operation and that of the County Medical Associations.

This legislation which returned the administration of relief back to the counties where it rightfully belongs, started operating on December 1, 1939. I could talk to you for a long time of the gain to the taxpayer in the efficiency and the economy of the relief programs under local control, and the advantages of a spending unit being close to the source of revenue. The importance of the medical profession in any program of relief is emphasized by the following figures from my own county of Kent.

We sent a total of one million, seven hundred and thirty-six thousand, seven hundred and seventeen dollars for direct relief in the years of 1940, 1941, 1942 and 1943. Of this amount, $114,255 was for medical care. Hospitalization took approximately 25 per cent out of every relief dollar. In this program, we must rely entirely on your help.

In Kent County, we have the largest number of old age assistance cases in comparison to population of any county in the state of Michigan. This is due to the fact that our metropolis is an old furniture city and our average age is much higher than those counties with cities that have made rapid growth from the automobile industry.

In this county, we have 5,800 old age assistance cases in comparison to 14,000 in Wayne County and 3,000 in Genesee County which is comparable to Kent in population. For this number of old age assistance cases, it must be borne in mind that each one is a potential medical or hospital problem. This has also created a problem in home nursing care. This is also a problem in many other counties.

We have been extremely fortunate here that the Sisters of the Carmelite Order have taken an interest in this problem and they purchased a lot and have plans drawn to build a one hundred and twenty bed nursing home and we believe this will help solve our problem.

Kent County is outstanding in the fact that the depression started here in 1925 when many of our furniture factories were forced to close. Of the 48,000 case histories in our files, many of them date back to 1925 and prior years. In the winter of 1933 and 1934, we had 50,000 people on relief in Kent County, or one person out of five in comparison to the total population. At the end of this war, however, we will be in a much better position than many industrial counties who have had a great influx of people coming from the South to work in their defense plants. Many of these people are spending their money as fast as they earn it and having lived under conditions as they exist in the northern states and with the high wages they have been able to earn, will not be willing to return to their former homes, but will start drifting around the state to different localities. Each day, social welfare deparments will be confronted with many new problems.

I know that our state association would oppose any legislation taking away any of the powers we have obtained and we would also direct all of our efforts to defeat legislation proposing to socialize medicine. For instance, under our present law, clients are given the right to choose their own physician, and no one in need of medical care or attention is denied this right. In fact, on the recommendation of family doctors, we have rehabilitated a great many persons who because of some physical

condition are unable to work. In no way can you spend public funds more wisely than to assist some person who is handicapped, if by an operation or medical care he can once more regain self-respect in being able to work and support his family.

In closing, I wish to state that our strength is in organization, and with the State Association of Supervisors and our State Association of Social Welfare Boards and others who are interested and whose interests are being jeopardized by crackpot legislation, pooling our strength, we should be able to prevent the passage of laws detrimental to good government. It is for this reason that we should keep in close contact with other organizations, and while we may not agree on some things, there are many in which we are in accord.

I would propose that the executive committees of the three organizations and the others who have the same interests, should get together at least once a year and discuss proposed legislation of interest to all of us.

Now, I would like to say something about the remark your President made of this proposed initiatory petition that they are passing this fall. It is the easiest thing in the world to get petitions filed. Very seldom do they fail. I can speak for our State Association and in that association, we have about two hundred and fifty active members and about sixteen hundred associate members. Now, when I speak of the associate members, I am speaking of the State Association of Supervisors, and I am sure that both of these groups, if you gentleman are going into this fight, if we could meet—our board of directors and our executive committee and that of the State Association of Supervisors—that a large share of both of those organizations would be glad to back you in this fight.

THE SPEAKER: I am sure we all appreciate Mr. Dean's comments here and the very fine talk he has given. We will have it permanently in our records.

We come now to the oxering of resolutions, but if you will wait a moment, I would like to make an announcement. Dr. Novy has asked that it be announced that the financial report of the Michigan Medical Service is on the chairs and he asks that you take one so that you may study it before the meeting of the Michigan Medical Service tomorrow afternoon.

We are now ready for the offering of resolutions:

VIII. Resolutions

VIII—1. MEDICAL VETERAN READJUSTMENT PROGRAM

Resolution No. 1 was presented by A. E. Catherwood, M.D., of Wayne County.

WHEREAS, more than 2,100 Michigan doctors of medicine in the armed services, where they have performed so brilliantly, will be returning soon, and the medical profession and this House of Delegates are faced with the immediate responsibility, as well as the privilege, of preparing to assist them in a realistic manner, and

WHEREAS, a study of the situation shows that the returning doctor will be faced by any one or a combination of these three problems: Where to locate, further professional education, finances, and

WHEREAS, there are many projects under way by various hospital staffs, local county medical societies, State societies, American Medical Association, American College of Surgeons, American College of Physicians, and others, indicating the necessity for co-ordination, therefore be it,

RESOLVED, that necessary funds be allocated by the Council of the Michigan State Medical Society to procure the full-time services of a Counsellor on postwar adjustments, said counsellor to be a part of the regular executive administration of the State Society, and be it further

RESOLVED, that the Michigan State Medical Society request each county society to appoint a postwar adjustment committee to co-operate with the counsellor.

DR. CATHERWOOD: Warren Babcock, M.D., has given this problem a great deal of thought and he is the man who originally had the idea of the Council to co-ordinate all our efforts and this was presented to the Wayne delegation and they were unanimous in approval of the presentation of this resolution.

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions. Are there any further resolutions?

IX. Amendments to Constitution and By-laws

IX—1. MEMBERSHIP FOR DISABLED VETERANS

(Chapter 8, Sec. 4

Resolution No. 2 was presented by C. L. Hess, M.D., of Bay.

WHEREAS, every reputable Doctor of Medicine, under license to practice medicine and surgery and midwifery by authority of the Michigan State Board of Registration in Medicine, is eligible for active membership in a component county society as provided in the Constitution, Article III, Section 2, and By-laws, Chapter 9, Section 3, irrespective of his being in active practice, although if not in active practice, he may be elected as Associate Member at the option of the component county society as provided in the Constitution, Article III, Section 4, and

WHEREAS, active members, becoming totally disabled while on active duty in the military forces of the United States, should have their state dues and assessments remitted,

BE IT RESOLVED, that Chapter 8, Section 4, of the By-laws be changed to read as follows:

"An active member in good standing shall not be required to pay his annual state dues and assessments during the years he is on active duty in the military forces of the United States and during the years he may be totally disabled immediately following such duty."

IX—2. PROCEDURE OF ETHICS

(Chapter 9, Sections 3 to 10 incl.; Chapter 5, Sec 4; Chapter 6, Sec. 9)

Resolution No. 3 was presented by C. L. Hess, M.D., of Bay.

WHEREAS, The Council has appointed a Special Committee to make a critical survey of the By-laws governing the procedures on unethical conduct and to recommend changes for the purpose of clarification and simplification of the procedures, and

WHEREAS, the present rules provide that a member, disciplined by his component county society, may appeal, first to the Councilor of his District, then to the Council, and finally to the Judicial Council of the American Medical Association, and whereas, a disciplined member should be allowed to appeal directly to the Council, so that the Councilor from his district may sit without prejudice at the hearing on an appeal which such member may make to the Council, and

WHEREAS, it is desirable to specify the length of term of members of the Committee on Ethics of the State Society and clarify the duties of the Committee,

BE IT RESOLVED, that Chapter 9, Section 3 of the By-laws have the third sentence of the first paragraph deleted and the procedure on disciplinary action by component county societies amended, so that Section 3 shall read as follows:

"Each component county society shall be the judge of the qualifications of its own members, but as such societies are the only portals to this Society and to the American Medical Association, every reputable practitioner of Medicine who meets the requirements specified in the Constitution, Article III, Section 2, shall be eligible to active membership.

"A component county society may expel, suspend, or otherwise discipline a member under such procedure as is specified in its Constitution and By-laws, provided he is served by registered mail with a written copy of the charges preferred against him, and given at least thirty days notice of a hearing at which he may offer defense against such charges. He may employ counsel. Efforts at conciliation and compromise shall precede all hearings.

"A member under disciplinary action may appeal to the Council of the State Society. However, such disciplinary action shall remain in effect during the time an appeal is pending. A report of the action taken shall be made by the component county society within thirty days to the Secretary of the State Society."

BE IT RESOLVED FURTHER, that Chapter 9, Section 4 of the By-laws be deleted and the following substituted therefor:

"A member of a component county society whose license has been revoked shall be dropped from membership automatically as of the date of revocation."

BE IT RESOLVED FURTHER, that Chapter 9, Section 5 of the By-laws be deleted and the subsequent Sections 6 to 10 be numbered 5 to 9, respectively.

BE IT RESOLVED FURTHER, that Chapter 5, Section 2 of the By-laws have the word "censor" deleted, so that the first sentence shall read as follows:

"Each Councilor shall be the organizer, advisor, and peacemaker for his district."

BE IT RESOLVED FURTHER, that Chapter 5, Section 4 of the By-laws be deleted and the procedure on appeal to the Council from disciplinary action be revised, so that Section 4 shall read as follows:

"A member disciplined by his component county society may file an appeal in writing to the Council within 90 days of such disciplinary order. This appeal shall be referred by the Council to the Committee on Ethics of the State Society for investigation and report. After giving at least 30 days' notice to the appealing member and his component county society, the Council shall hold a hearing on the appeal under such rules as it may adopt. The Council shall review the record of the original proceedings and may obtain additional evidence. Its decision shall be final except that within the next 90 days a further appeal may be made to the Judicial Council of the American Medical Association."

BE IT RESOLVED FURTHER, that Chapter 6, Section 9 of the By-laws be deleted and the following substituted therefor:

"The Committee on Ethics shall consist of eight members appointed by the President with the approval of the Council, each member to serve for a four-year term, so staggered that two members are selected annually, provided that: in 1944 the term of two members shall be for four years, two for three years, two for two years and two for one year, In case a vacancy

occurs before the expiration of a member's term the President shall appoint a successor to serve the unexpired portion of the term,

"The Committee shall render advisory opinions on questions of ethics submitted to it by the Council.

"On request of the Council it shall conduct an investigation, under rules approved by the Council, concerning the ethical conduct of a designated member of this Society and report its findings to the Council."

IX-3. COMMITTEE ON CANCER CONTROL (Chapter 6, Sec. 6)

Resolution No. 4 was presented by C. L. Hess, M.D., of Bay.

BE IT RESOLVED, that the name of the "Committee on Cancer," as given in Chapter 6, Section 6 of the By-laws, be changed to the present name of this committee and read as follows: "Committee on Cancer Control."

IX—4. CHANGING "MEETING" TO "SESSION" (Chapter 3, Sec. 7-M)

Resolution No. 5 was presented by C. L. Hess, M.D., of Bay.

BE IT RESOLVED, that Chapter 3, Section 7, paragraph m, first sentence of the By-laws have the words "session" and "meeting" interchanged, so that the first sentence shall read as follows:

"The election of officers shall be held at the last *meeting* of the House of Delegates at the Annual *Session.*"

IX-5. TERM OF MSMS'S REPRESENTATIVES TO JOINT COMMITTEE ON HEALTH EDUCATION (Chapter 6, Sec. 5)

Resolution No. 6 was presented by C. L. Hess, M.D., of Bay.

WHEREAS, it is desirable to clarify the appointment and the length of terms of representatives on the Joint Committee on Health Education,

BE IT RESOLVED, that Chapter 6, Section 5 of the By-laws be revised, so that it shall read as follows:

"The Society's representatives on the Joint Committee on Health Education shall consist of five members, appointed by the President with the approval of the Council, each member to serve for a five-year term, so staggered that one member is selected annually, provided that in 1944 the term of one member shall be for five years, one for four years, one for three years, one for two years, and one for one year. In case a vacancy occurs, the President shall appoint a successor to serve the unexpired portion of the term."

IX-6. TERM OF MEMBERS OF COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION (Chapter 6, Sec. 7)

Resolution No. 7 was presented by C. L. Hess, M.D., of Bay.

WHEREAS, the present Committee on Postgraduate Medical Education now consists of twelve members including a chairman and an assistant chairman and the length of the term of a member should be more clearly specified,

BE IT RESOLVED, that Chapter 6, Section 7 of the By-laws have the first paragraph deleted and the following substituted therefor:

"The Committee on Postgraduate Medical Education shall consist of twelve members, appointed by the President with the approval of the Council, each member to serve for a three-year term, so staggered that four members are selected annually, provided that in 1944 the term of four members shall be for three years, four for two years and four for one year. In case a vacancy occurs before the expiration of a member's term, the President shall appoint a successor to serve the unexpired portion of the term."

THE SPEAKER: These resolutions will be referred to the Committee on Amendments to the Constitution and By-Laws.

(Continued in January, 1945)

YOU AND YOUR BUSINESS

The 1945 Postgraduate Conference on War Medicine—The 80th Annual Session of the Michigan State Medical Society will be held in Detroit on September 19-20-21, 1945. The Book-Cadillac Hotel will be headquarters. The Woman's Auxiliary will also meet on September 19-20 with headquarters at the Statler Hotel, Detroit.

COUNTY SECRETARIES CONFERENCE, JANUARY 28

An extraordinary program (see page 1120) has been arranged for the Annual County Secretaries' Conference and School of Information, scheduled for the Book-Cadillac Hotel, Detroit, Sunday, January 28, 1945. This meeting is a MUST for Secretaries and Presidents of County Medical Societies. Moreover, its timely interest should attract other officers and members of Michigan's fifty-five county medical societies. All are cordially invited.

MEDICAL DIRECTORIES

"Who's Important In Medicine" of 320 Broadway, New York 7, is writing Michigan physicians that they are to be honored by having their names in the 1944 compilation of "Who's Important In Medicine." For information on this organization, contact the Executive Office, 2010 Olds Tower, Lansing 8.

Another firm sending postal-card questionnaires to Doctors is the *"Academy Publishing Bureau,* 509 Minnesota Street, St. Paul, Minnesota." The heading of the card is styled: "Academy-International of Medicine and Dentistry," with a subtitle of "Medical Section, Academy-International of Medicine." The recipient is told by the publisher that he is "one of a very limited number of practitioners from whom data is requested." Information on this activity is also available to members of the Michigan State Medical Society.

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In Memoriam

KILLED IN ACTION

Bertram W. Morse of Whitehall was born in 1901 and was graduated from Wayne University College of Medicine in 1932. He located in Whitehall in 1934 and served as health officer for seven years and as vice president of the Whitehall Chamber of Commerce. He enlisted in May, 1942, and was given a captain's commission, rising to the rank of major one year ago. He was exceedingly interested in plastic surgery and hoped to specialize in that field when he returned to civilian life. He was killed in action in France August 29, 1944. Doctor Morse was the first Doctor of Medicine from Muskegon County to lose his life in the war.

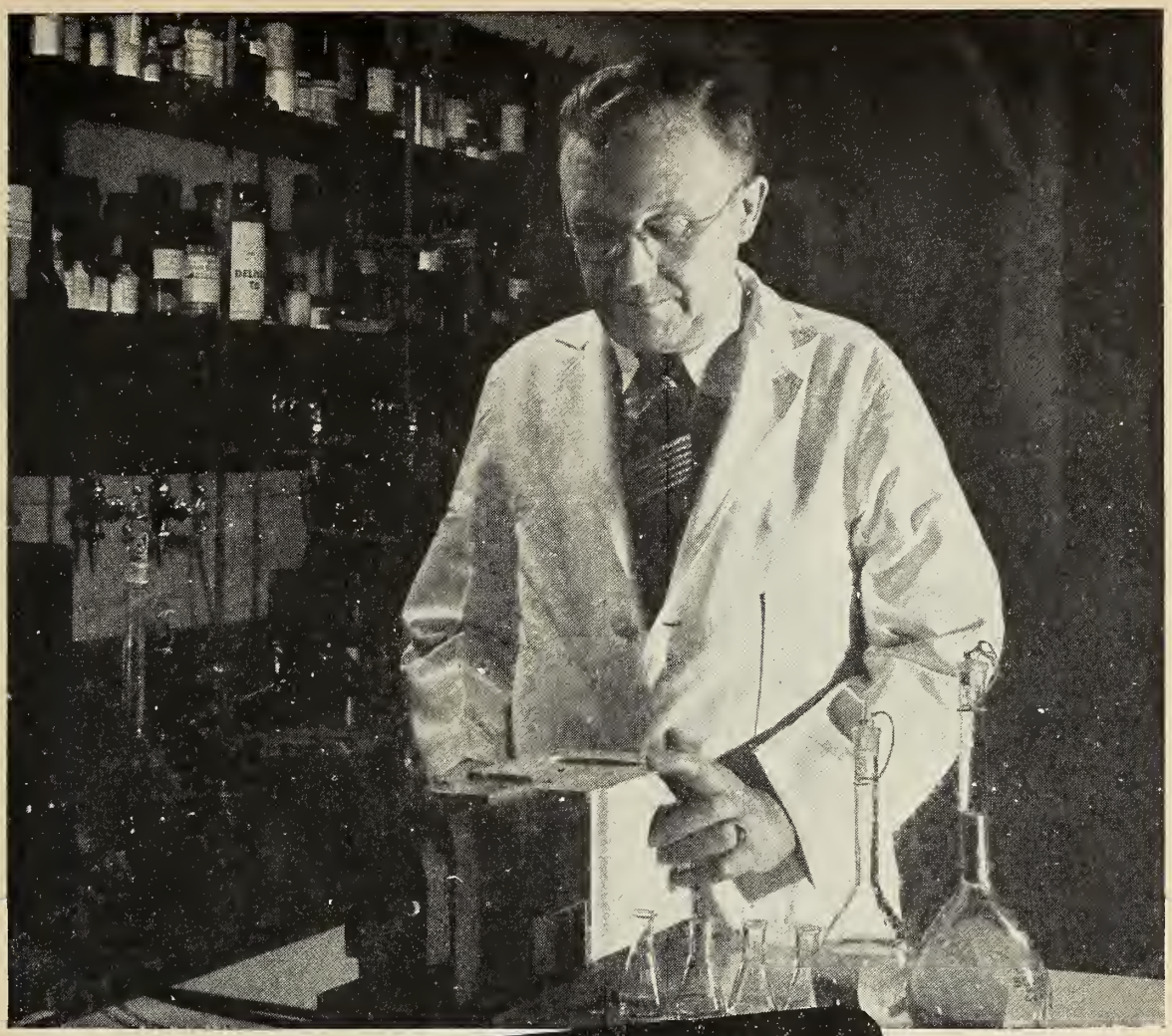
Vito V. Stabile was born February 9, 1917 in Boston and was graduated from Wayne University College of Medicine. He interned at Grace Hospital from March to December, 1943. At the time of his death, June 19, 1944, he was serving as a Lieutenant in the Naval Reserve, Medical Corps, and was killed in action while transporting wounded from France to England following the recent D-Day Invasion.

Lloyd H. Childs of Flint was born August 31, 1886 at Adrian and was graduated from the University of Michigan Medical School in 1910. He practiced in South Dakota one year before going to Flint. He was medical director of Chevrolet Motor Division in Detroit for five years, and in Flint for twenty-eight years. He was a member of the American Association of Industrial Physicians and Surgeons and many other professional and civic organizations. He died September 18, 1944.

Robert C. Laird of Detroit was born in 1894 in Ireland and was graduated from Wayne University College of Medicine in 1928. He had practiced in Detroit the last sixteen years. Doctor Laird was a fine physician and had a large and enthusiastic following among his patients and his early demise will be much regretted by his friends in the medical profession.

William C. Martin of Detroit was born in 1870 and was graduated from Wayne University College of Medicine in 1890, after which he went to Berlin for postgraduate work. In 1894 he began teaching in Wayne University College of Medicine and continued until 1929. He had practiced medicine for fifty years in Detroit. He was elected to Emeritus Membership in

Say you saw it in the Journal of the Michigan State Medical Society



WHAT ARE WE LOOKING FOR?

In research on the sulfa drugs we are investigating the long list of possible chemical analogues of sulfanilamide . . . seeking compounds of greater effectiveness and less toxicity. But our studies go far deeper than that . . . we are inquiring into the interference of various substances with the action of sulfonamide drugs, for through a knowledge of the mechanics of these inhibitory agents we hope, in turn, to learn more about the action of the sulfas, and thus throw new light on this important field of chemotherapy.



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the Michigan State Medical Society in 1941. He died September 15, 1944.

Charles R. Sheridan of Detroit was born in Cumberland, Md., and was graduated from Georgetown University and the University of Maryland. He began his practice in 1906 for a mining corporation near his native city. In 1913 he went to Detroit and was a physician first at St. Mary's Hospital and later at St. Francis in Hamtramck which he was instrumental in building. He was health commissioner in Hamtramck for six years. He died October 3, 1944, after a long illness.

William A. Smith of Petersburg was born in Chagrin Falls, June 8, 1887, and was graduated from the Homeopathic Medical College in Cleveland in 1903. He located in Petersburg after his graduation, where he built up a large practice. Doctor Smith served as president of Monroe County Medical Society in 1926-27. He became president of the H. C. McLachlin & Co. State Bank in 1930, which position he held until his death. He had served for twenty-one years as a member of the school board and was active in many civic organizations. He died on July 9, 1944.

John N. Swartz of Detroit was born in 1871 at Barnesville, Pa., and was graduated from the University of Michigan Medical School in 1892. After graduation he located in Detroit, where he had practiced until the time of his death, September 26, 1944.

WHOLE BLOOD FLOWN DIRECT TO PARIS

Blood from American civilians is now flowing through the veins of soldiers wounded in Europe within twenty-four hours after it is donated in this country! On October 12 the Army Transport Command began flying whole blood direct to Paris instead of first to a relay station in Scotland. As a result the blood is available for transfusion within 24 hours after it is drawn from "O" type donors in Boston, New York and Washington. More than 750 pints are now being flown across daily—but the need for both whole blood and plasma is becoming more and more urgent as the number of casualties increases.

GRANT TO WAYNE UNIVERSITY

Acceptance of a $3,000 grant to the Wayne University College of Medicine from Merck and Company, Incorporated, was approved by the Board of Education at its last meeting. The fund will be used in the department of surgery for a clinical investigation of antibiotics and streptolysin.

Say you saw it in the Journal of the Michigan State Medical Society

The macrocytic anemias in pregnancy respond to

Solution LIVER EXTRACT *Lederle*



MACROCYTIC ANEMIAS in pregnancy resemble other macrocytic anemias. This type of anemia frequently responds best to a complete antipernicious anemia regime, including the injection of liver extract, vitamin therapy, a diet adequate in protein, and iron by mouth when there is evidence of hypochromia.

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(4) 3-5 cc. vials (10 U.S.P. XII injectable units each vial)

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(5) 3-1 cc. vials (15 U.S.P. XII units each)
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Woman's Auxiliary

THE SEASON'S GREETINGS

May the holiday season bring you joy; if not the merry Christmas of former years, at least the joy that achievement brings.



The knowledge that we, as auxiliary members, have endeavored to maintain a cheerful home for our families, have assumed a fair share of the war effort, and are striving to preserve the American way of life—which our soldiers are fighting for—should bring a deep sense of happiness to all of us.

My very best wishes for a happy Christmas and for all the days of the coming year!

LELA FRENCH

* * *

Have you received your copy of the *Auxiliary News?* If not, please notify Mrs. C. F. DeVries, Box 430, R. R. 1, Lansing, and one will be mailed to you.

THE GRAND RAPIDS MEETING

The eighteenth annual meeting of the Woman's Auxiliary to the Michigan State Medical Society was held in Grand Rapids, September 27-28, 1944, at the Hotel Pantlind.

Registration opened on Tuesday at 1:00 p.m. under the capable chairmanship of Mrs. John Ten Have. She reported sixty-one delegates, 146 members and seven guests present.

A dinner for the Past Presidents and Secretaries Club was held Tuesday evening at 6:30 o'clock in the Country House. Mrs. Guy L. Kiefer, honorary state president and present president of the club, presided. Mrs. Wm. J. Butler, Mrs. H. J. Pyle, Mrs. A. V. Wenger, and Mrs. Carl Snapp entertained at a pre-dinner party in the home of Mrs. Butler.

1943-1944 Board members and county presidents were complimented at the pre-convention Board meeting and luncheon held in the Schubert Room. All members were welcome to attend.

Members of Kent County Auxiliary were hostesses at a tea in honor of Mrs. David W. Thomas, President of the Woman's Auxiliary to the American Medical Association in the Continental Room. The tea table was decorated with a large white bowl filled with gladioli. Mrs. Merrill Wells and Mrs. Lynn A. Ferguson poured. Following, Mrs. Richard Gregory presented a costume impersonation of the first woman doctor of mysterious Mayaland, Consuelo Vadillo. This was thoroughly enjoyed.

Wednesday evening at 7 o'clock, Mrs. John J. Walch presided at the informal banquet in the Grill Room. The tables were beautifully decorated with arrangements of chrysanthemums and vegetables. The national anthem was led by Mrs. Thomas C. Irwin and Mrs. William R. Torgerson. Invocation was given by Mrs. Guy L. Kiefer. Mrs. Dixon gave the address of welcome, after which past presidents and honored guests were presented, one being Dr. A. S. Brunk, president of the Michigan State Medical Society. Mrs. Alexander M. Martin presented a very delightful fashion review during the dinner. Mrs. David W. Thomas, the national president, spoke of the development and growth of the organization of the Auxiliary and explained the two major projects for the year: (1) Juvenile Delinquency—"Prevention from the Medical Aspect," and (2) The Physical Fitness Program. She said, "Keep health leadership where it belongs, with the medical profession." She suggested reading the article "Keep Fit and Like it," in the September issue of *Hygeia.* The banquet adjourned in time for members to attend the Officers' Night program of the Michigan State Medical Society.

The convention was formally opened Thursday at 9:00 a.m. in the Amber Room by Mrs. John J. Walch, state president. The Pledge of Allegiance was conducted by Mrs. W. Sherman of Detroit. Dr. Frank E. Reeder, chairman of the Advisory Council, welcomed the Auxiliary. Mrs. Merrill Wells, president of Kent County, welcomed the members. Mrs. Lloyd C. Harvie, Saginaw, gave the response.

The "In Memoriam" service was given by Mrs. Homer Stryker of Kalamazoo.

Mrs. Willis Dixon, Grand Rapids convention chairman, thanked her committees. The minutes of the seventeenth annual meeting were read by Mrs. Otto Hult. Mrs. Homer Ramsdall, Manistee, read the convention Rules of Order.

Mrs. Walch, in her president's message, stated that she had visited seventeen counties and attended the midyear board meeting of the AMA, the midyear board meeting of the Michigan Auxiliary, the AMA Auxiliary convention, the School of Information in January in Detroit, and a meeting of the Michigan Nursing Council of War Service. Two issues of the *Auxiliary News* were edited. She wrote 300 letters and fifty cards. She praised the counties for their activities and urged their continuance for the coming year.

State chairmen and county presidents gave reports. Officers for the coming year are as follows:

President—Mrs. H. L. French, 1620 W. Main St., Lansing 15

President-elect—Mrs. Lloyd C. Harvie, 417 Arduasi, Saginaw

Vice President—Mrs. R. H. Alter, 801 S. West Ave., Jackson

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(Continued on Page 1110)



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Mrs. H. L. French gave a report on the AMA Auxiliary convention held in Chicago.

At 12:30 o'clock, the annual luncheon was held in the Grill Room with Mrs. John J. Walch presiding. The National Anthem was led by R. J. McCandliss, M.D., accompanied by Mrs. McCandliss. Rev. Edward A. Mohns gave the invocation. Professor Floyd E. Armstrong, professor of economics at the Massachusetts Institute of Technology, spoke on "Women in the Postwar Economic World." His message was, "Inform yourself about the economics of your own home."

The post convention Board meeting was held in the Amber Room at 3:30 with Mrs. H. L. French, the new president, presiding State chairmen and county presidents of 1944-1945 told of their plans for the coming year.

Mrs. H. L. French entertained at a tea honoring Mrs. John J. Walch following the board meeting.

Great credit is due Mrs. John J. Walch, Mrs. Willis L. Dixon and the Kent County Auxiliary for an outstanding convention.

Wayne County.—A luncheon at the Whittier Hotel, October 13, opened the season of 1944-45. A board meeting at 10:30 a.m. preceded the luncheon. Lillian Beal Hicks gave a program of Dolly Madison. Mrs. Hicks is widely known as a coloratura soprano as well as for her dramatic ability.

The Ways and Means Committee on October 20 sponsored a rummage sale, proceeds of which are being used for war projects including the rehabilitation program at Percy Jones Hospital at Battle Creek.

St. Clair County.—The Auxiliary joined with the St. Clair County Medical Society for dinner at Wesley Hall, First M. E. Church, Port Huron, October 10, followed by an address, "What Price Security," by Professor Floyd E. Armstrong. The dinner and meeting were open to the public.

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SURGICAL TREATMENT OF GALL-BLADDER DISEASE

(Continued from Page 1088)

now it is in the neighborhood of 3 per cent in most good clinics. When complications have developed prior to operation, the mortality rate rises.

In the vast majority of patients, the relief of symptoms following cholecystectomy is complete and gratifying to both patient and surgeon. Unfortunately we have all seen the occasional patient who is not relieved of symptoms or who is worse after operation than before. Failure to achieve a satisfactory result is most frequently due to failure to make a satisfactory diagnosis, i.e., to remove a gall bladder which is nearly normal, and overlook some other cause such as pancreatitis, duodenitis, spastic colitis or some other abnormality. Careful evaluation of the evidence of cholecystic disease before operation is the most effective way to avoid this pitfall. Another cause of poor results is a poorly performed operation, such as overlooking a stone in the common duct, incomplete removal of the gall bladder, or extensive trauma at the time of operation leading to excessive production of adhesions. With accurate diagnosis and a satisfactorily performed operation, good results should be expected and attained.

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Say you saw it in the Journal of the Michigan State Medical Society

✶ COUNTY AND PERSONAL ACTIVITIES ✶

Gordon B Myers, M.D., Detroit, is co-author of an original article entitled "The Male Climacteric, Its Symptomatology, Diagnosis and Treatment," which appeared in JAMA of October 21, 1944.

* * *

Raymond W. Waggoner, M.D., Ann Arbor, is co-author of an original article entitled "Psychiatric Selection of Men for the Armed Forces," which appeared in JAMA of September 23, 1944.

* * *

The Michigan State Board of Registration in Medicine announced on October 27 the revocation of the license of Marshall Cullen Sexton, M.D., of Columbus, Ohio, and the suspension for one year of the license of Guy Garland Alway, M.D., of Ann Arbor, and the suspension of the license of LeRoy Wellstad, M.D., of Ottumwa, Iowa, for violations of the Medical Practice Act.

* * *

The Second Annual Clinical Conference of the Chicago Medical Society will be held at the Palmer House, Chicago, on February 27, 28 and March 1, 1945. The sponsoring of this Conference for physicians of the Middle West has become an important function of the Chicago Medical Society following its inauguration last Spring. The Committee is already under way in securing speakers on important subjects for the 1945 session to which all members of the Michigan State Medical Society are cordially invited.

* * *

Urology Award.—The American Urological Association offers its annual award "not to exceed $500" for an essay on the result of some specific clinical or laboratory research in Urology. Competitors are limited to residents in Urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. Essays must be in the hands of Secretary Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 15, 1945.

* * *

Lawrence Reynolds, M.D., Detroit, was guest speaker at the Eleventh Annual Postgraduate Day of the Medical Institute of the University of Toledo, held in Toledo, Ohio, on November 3. Dr. Reynold's subject was "Pseudo Fractures and some Medical Legal Problems in connection with General Practice."

This year's Institute was dedicated as a memorial to the late John T. Murphy, nationally recognized pioneer in radiology, who died in June.

* * *

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and supplies sorely needed by the service branches of the Government, that it can readily be assumed that subversive activities are on such a huge scale that they are undermining our constitutional form of government, the free enterprise system, the right to work, enjoy the unmolested sanctity of our homes, and a suspension of the seizure of property without due process of law."—Detroit Board of Commerce, May 18, 1944.

* * *

Committees of The Council, Michigan State Medical Society, 1944-45:

Finance Committee: C. E. Umphrey, M.D., Chairman, W. E. Barstow, M.D., T. E. DeGurse, M.D., W. H. Huron, M.D., A. B. Smith, M.D.

Publication Committee: Ray S. Morrish, M.D., Chairman, O. O. Beck, M.D., A. H. Miller, M.D., Dean W. Myers, M.D., R. C. Perkins, M.D.

County Societies Committee: O. D. Stryker, M.D., Chairman, Wilfrid Haughey, M.D., R. J. Hubbell, M.D., P. A. Riley, M.D., E. R. Witwer, M.D.

* * *

Michigan speakers on the program of the Fifty-fifth Annual Meeting of the Association of American Medical Colleges, held in Detroit October 23, 24, 25, were: Gordon B. Myers, M.D., L. S. Woodworth, M.D., and Daniel E. Hasley, M.D., all of Detroit.

A. C. Furstenberg, M.D., of Ann Arbor was inducted into the presidency of the Association at the Detroit meeting.

Tit for Tat—A physician in another city recently received three neckties unordered from an eastern mail order house. Accompanying the ties was a letter reading as follows: "Dear Doctor: We are taking the liberty of sending you three exceptionally fine ties. We know you will like them. Please send us $2." Here is the physician's reply: "I am taking the liberty of sending you $2 worth of extra fine pills. These pills have helped thousands and I am sure you will appreciate my thoughtfulness in sending them to you. Please accept them in payment of the ties you sent me."

* * *

An appreciation to the MSMS Committee on Postgraduate Medical Education: "Yesterday I received a certificate of Fellowship in Postgraduate Education issued by the Michigan State Medical Society. I was really thrilled on receiving this and I prize very much the work that I took under the direction of your Committee which this Fellowship represents. Thanks a lot for your kind letter of congratulations. Although at the present time I am some distance from the state of Michigan, I am still much interested in the educational program carried on by the Medical Society there." —Lyle C. Shepard, M.D., Glendale Sanitarium and Hospital, Glendale, California.

* * *

A. S. Brunk, M.D., president of the Michigan State Medical Society, was guest speaker at the AMA Secretaries' Conference of November 17-18. His subject was

Say you saw it in the Journal of the Michigan State Medical Society

"Radio Advertising by the Medical Profession," in which he outlined the experiment of the Michigan State Medical Society in purchasing radio time to bring to the poeple dramatized incidents in the lives of private practitioners of medicine.

Dr. Brunk also was guest speaker at the session of the House of Delegates of the Iowa State Medical Society held in Des Moines on November 1. He outlined the work of Michigan Medical Service. He also spoke on invitation to the Permanent Study Committee on Health Insurance of the Indiana State Medical Association on November 12 in Indianapolis concerning the formation, principles and activity of Michigan Medical Service.

* * *

Radio Presentations sponsored by the MSMS Radio Committee (Russell N. DeJong, M.D., Chairman), during November and December are as follows:

November 2—Dr. Otto K. Engelke, Health Officer, Washtenaw County Health Department, Ann Arbor: The Role of the Parent in the Control of the Dangerous Contagious Diseases.

November 9—Miss Rhoda F. Reddig, Professor of Nursing and Director of the University of Michigan School of Nursing: Some Answers to Questions Concerning Nursing.

November 16—Dr. Gordon K. Moe, Assistant Professor of Pharmacology in the University of Michigan Medical School: Recent Advances in the Treatment of Thyroid Disease.

November 23—Thanksgiving.

November 30—Dr. Carl A. Moyer, Director of Surgery at the William J. Seymour Hospital, Eloise, Michigan: The Dog and Modern Medicine.

December 7—Dr. Herman H. Riecker, Assistant in Postgraduate Medicine in the University of Michigan: The Prevention of Heart Disease in Middle Life.

December 14—Dr. Paul S. Barker, Associate Professor of Internal Medicine in the University of Michigan Medical School: Recent Advances in the Care of Heart Disease.

December 21—Dr. Joseph G. Molner, Deputy Commissioner and Medical Director, City of Detroit Department of Health, and Assistant Professor of Preventive Medicine and Public Health in the Wayne University College of Medicine: Protection of Children Against Disease.

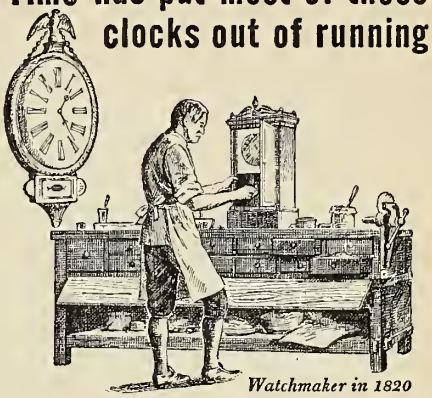
December 28—Dr. Loren W. Shaffer, Director of Social Hygiene Division, City of Detroit Department of Health, and Professor of Dermatology and Syphilology in the Wayne University College of Medicine: The National Program for Venereal Disease Control.

* * *

PHYSICAL REHABILITATION

The Medical Advisory Committee of Physical Rehabilitation met October 22, 1944, to study the subject. The Federal Government is interested in this subject, and has provided by law that the best of services

Time has put most of these clocks out of running



Watchmaker in 1820

But time has added to Johnnie Walker's popularity

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shall be made available for rehabilitation of physically handicapped persons, and this applies to those handicapped from all sorts of causes, other than war casualties. This rehabilitation program is now estimated at about ten per cent of the patients that visit the doctors' offices, but it is expected that it will soon be twenty-five per cent. This is a program that all the doctors are of necessity interested in.

POSTGRADUATE EDUCATION

Butterworth Hospital, Grand Rapids, sent a news letter to all its staff men in the services on August 12, 1944, as follows: "Your hospital is now approved by the American College of Surgeons for graduate training in surgery. We had been previously approved by the Council on Medical Education and Hospitals of the American Medical Association, so this new approval by the College makes us fully approved by all rating "bodies."

There is a committee of the Michigan State Medical Society to study and make recommendations for postgraduate training for our returned medical officers. Any who wish residency or postgraduate training should write to Dr. B. R. Corbus, chairman, telling what type of training he is mostly interested in, and the committee and society will do its best to see that it is forthcoming.

MEDICAL WOMEN'S ASSOCIATIONS MERGE

On Tuesday, October 24, an amalgamation of the Blackwell Society of Detroit and the Michigan Branch of the American Medical Women's Association was effected. The new organization is to be known by the name "The Blackwell Branch 20, of the American Medical Women's Association." Dr. Hallie Hartgraves, Regional Director of the A.M.W.A. in this area, presided at the meeting. The following officers were elected:

President.....Dr. Harriet E. McLane
Vice President.....Dr. Rose E. Herrold
Treasurer.....Dr. Delma F. Thomas
Secretary.....Dr. Esther H. Dale
President-Elect.....Dr. Fanny Kenyon

Additional members to serve on the Board were elected as follows: Dr. Mary B. Campbell, Dr. Frances L. MacCracken, Dr. Martha Wells, and Dr. Bertha Selmon.

THE "NATIONAL MEDICAL SOCIETY"

"The Directors of the National Medical Society cordially invite Dr. X to membership in the National Medical Society," reads an invitation mailed gratuitously to a number of doctors of medicine during the past several months. The invitation states, "Please reply to Dr. Hans Zimmerman, Executive Secretary, National Medical Society, 116 South Michigan Ave., Chicago 3, Ill."

The invitation further states, "The National Medical

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Society welcomes to its membership all ethical members of the medical profession, regardless of medical creed. Homeopathy, Eclecticism, Osteopathy, and Naturopathy (physical medicine) all have an honored place and responsibility in the field of therapeutics." Further, it states, "The membership dues are $10.00 the first year and $6.00 annually thereafter."

A clipping from *The Chicago Tribune* of August 20, 1943, shows a picture of Hans Zimmerman, referred to in the newspaper item as a naturopathic physician "who had made his home in Chicago since he was released suddenly by the federal bureau of investigation from the Army's custody last March." According to Zimmerman's statement as quoted in this item, he was born in Germany and came to this country in 1927. The statement attributed to him in the newspaper clipping was a long recital of what happened to him at the time he apparently was interned at Camp McCoy.

Another clipping, taken from the *Rochester, New York, Democrat and Chronicle* for August 17, 1944, gives an account of a celebration of the 76th birthday of Bernarr Macfadden. Among those who, according to the newspaper clipping, were present on that occasion was one "Dr. Hans Zimmerman, who presented an honorary life membership certificate in the National Medical Society to Mr. Macfadden."

* * *

COUNCIL AND COMMITTEE MEETINGS

Advisory Committee on Radio of Public Relations Committee—Detroit, August 29.

Postwar Education Committee, Statler Hotel—Detroit, September 14.

Maternal Health Committee, Pantlind Hotel—Grand Rapids, September 28.

Venereal Disease Control Committee, Pantlind Hotel—Grand Rapids, September 28.

The Council, Pantlind Hotel—Grand Rapids, September 25, 28.

Executive Committee of The Council, Book-Cadillac Hotel—Detroit, October 11.

Medical Advisory Committee on Physical Rehabilitation—Porter Hotel, Lansing, October 22.

Maternal Health Committee, Wayne County Medical Society—Detroit, October 26.

Committee on Scientific Work, Porter Hotel—Lansing, November 5.

Insurance Panel Committee—Detroit, November 9.

Executive Committee of The Council, Book-Cadillac Hotel—Detroit, November 9.

Procurement and Assignment Committee, Book-Cadillac Hotel—Detroit, November 9.

Medical Advisory Committee on Rehabilitation—Porter Hotel, Lansing, December 3.

Legislative Committee, Wayne County Medical Society—Detroit, December 7.

Coming Meetings

Annual Session of The Council, Book-Cadillac Hotel—Detroit, January 25, 26, 27, 1945.

Legislative Committee, Book-Cadillac Hotel—Detroit, January 27, 1945.

Annual County Secretaries' Conference—Book-Cadillac Hotel, Detroit, January 28, 1945.

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COUNTY SECRETARIES' CONFERENCE

The MSMS Annual County Secretaries' Conference and School of Information will be held at the Book-Cadillac Hotel, Detroit, on Sunday, January 28, 1945. County medical society secretaries, presidents and editors will be particularly interested in this socio-economic conference for which an excellent program is being arranged.

Tentative Program

9:30 a.m. to 5:30 p.m.

1. "First Things First"—W. W. Bauer, M.D., Chicago, Director, Bureau of Health Education of American Medical Association.
2. "The Selling Job of the Michigan Medical Profession—What Must Be Done *NOW*"—John F. Hunt, Chicago, Executive and Director of Research, Foote, Cone, & Belding.
3. "The Aims and Purposes of the Michigan Physicians Committee"—Edward F. Stegen, Chicago, Associate Administrator of National Physicians Committee.
4. "The Proposed Amendment to the Constitution of the State of Michigan"—Paul D. Bagwell, East Lansing, Director of Speech Department, Michigan State College.
5. "The Work of the Washington Office of the Council on Medical Service and Public Relations"—Joseph S. Lawrence, M.D., Washington, D. C., Director, Council on Medical Service and Public Relations, American Medical Association.
6. "The Physical Rehabilitation Program of the Federal Government"—E. F. Sladek, M.D., Traverse City, Michigan, Chairman of The Council, Michigan State Medical Society.

Two discussion periods will be held, one immediately before the noon-day dinner, scheduled for the Book-Cadillac Hotel at 12:00 Noon, and the second between 3:30 and 4:30 p.m.

All members of the Michigan State Medical Society and of the Woman's Auxiliary are cordially invited to attend the Conference of January 28 in Detroit.

Will You Be There?

Those who attended last year pronounced the Conference a real success. They'll be back. You're invited too. Three intensive Postgraduate Days in a Great Medical Center.

Chicago Medical Society
Annual Clinical Conference
February 27-28 and March 1, 1945
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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

PRESCRIPTION FOR PERMANENT PEACE. By William S. Sadler, M.D., Consulting Psychiatrist, Columbus Hospital; Author, Theory and Practice of Psychiatry, The Mind at Mischief, Living a Sane Sex Life, Growing Out of Babyhood, et cetera. Chicago: Wilcox and Follett Co., 1944. Price 2.50.

Dr. Sadler is a practical psychiatrist, seeing the simple and obvious as well as the intricate; and abhoring large impressive words which mean nothing to the average person. Here he is seeing nations as he has been trained to see individuals. His ideas are interesting and challenging. For your relaxation and entertainment this book should be read. It will disturb your reveries, and set you to some real thinking.

* * *

OPERATIONS OF GENERAL SURGERY. By Thomas G. Orr, M.D., Professor of Surgery, University of Kansas School of Medicine, Kansas City, Kansas. 723 pages with 1,396 step-by-step illustrations on 570 figures. Philadelphia and London: W. B. Saunders Company, 1944. Price $10.00.

This is a very fine piece of work for the busy practicing general surgeon. While Dr. Orr makes no pretense of covering all of the fine points of each specialty in surgery yet he is plenty comprehensive enough to include all of the necessary knowledge for the practicing surgeon in the field. Every essential operation is covered clearly, simply, and concisely as to indications, anatomy, technique, and pitfalls.

While the author has devoted the greater part of this book to operational technique, yet there is enough other material to make it much worth while from many other angles. For instance, his chapter on wound healing and suture material are more than helpful in orienting one right up to the present. His lucid description of surgical pitfalls constitutes warning enough to make the untrained man stay away from situations where he doesn't belong.

Certainly this is a book which can well be on any doctor's shelf.

MANUAL OF MILITARY NEUROPSYCHIATRY. Edited by Harry S. Solomon, M.D., Professor of Psychiatry, Harvard Medical School; Medical Director of the Boston Psychopathic Hospital; and by Paul I. Yakovlev, M.D., Clinical Director. Walter E. Fernald State School; Instructor in Neurology at the Harvard Medical School. With collaborators. Philadelphia and London: W. B. Saunders Company, 1944. Price $6.00.

The present manual has been prepared primarily as a reference textbook on topics of clinical neurology and psychiatry, and especially for medical officers in service remote from libraries and references. Part III—Administration and Disposition—had to be curtailed for there is much information not now suitable for publication. The same holds for the part about Prophylaxis and Therapy of neuropsychiatric casualties. The administration of induction stations is by a medical officer, and forms a basis for the study of all sorts of abnormal behavior states as they appear in mili-

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CLINICAL UROLOGY. By Oswald Swinney Lowsley, A.B., M.D., F.A.C.S., Attending Surgeon of the Department of Urology (James Buchanan Brady Foundation) of the New York Hospital. Drawings by William P. Didusch. Second Edition, Volume 1-Vol. 11. Baltimore: The Williams & Wilkins Company, 1944. Price $10.00 per set.

This two-volume set of books is one of the most practical expositions of the anomalies and diseases of the genito-urinary tract. It is written for the specialist with full knowledge that the busy general practitioner will have to consult it often, and the wording and descriptions are in keeping. Diagnosis is given full consideration but the stress is on modern and effective treatment, with especial attention to the chemotherapy of the last few years. Up-to-date references are included for the benefit of the trained urologist.

TEXTBOOK OF GYNECOLOGY. By Emil Novak, M.D., F.A.C.S., Associate in Gynecology, the Johns Hopkins Medical School, Bon Secours and St. Agnes Hospitals, Baltimore; Second Edition. Baltimore: The William & Wilkins Company. 1944. Price $8.00.

The demand for a second edition of this work speaks for its excellence. Two new chapters have been added, and much new material throughout the book, which is larger than its predecessor. The subjects of gynecology and female endocrinology have been treated not only for the needs of the medical student but for the practitioner as well. The details of diagnosis and treatment have been especially emphasized. Illustrations are good and profuse.



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GYNECOLOGICAL AND OBSTETRICAL UROLOGY. By Houston S. Everett, A.B., A.M., M.D., Associate Professor of Gynecology, The Johns Hopkins University, and Associate in Gynecology, the University of Maryland; Assistant Visiting Gynecologist and Gynecologist in Charge of the Cystoscopic Clinic, The Johns Hopkins Hospital. Baltimore: The Williams & Wilkins Company, 1944. Price $6.00.

There have been abundant and voluminous volumes on Urology, covering to some extent the question as it related to female patients. Dr. Everett has brought us a volume of exceptional interest and value, because it is confined to the deformities and diseases of the genito-urinary tract in especial reference to obstetrics and gynecology. The material for this work has accumulated while teaching at Johns Hopkins, and is beautifully presented, with descriptions of the use of the Kelly cystoscope, outstanding illustrations of the conditions and procedures described, and profuse use of the x-ray. The book pays minute attention to treatment and prognosis. A book for the use of the general man who needs help, and a reference and guide for the obstetrician and gynecologist whose patients want relief from obscure conditions.

DISEASES OF THE DIGESTIVE SYSTEM. Edited by Sidney A. Portis, B.S., M.D., F.A.C.P., Associate Professor of Medicine, University of Illinois Medical School (Rush), Attending Physician, Michael Reese Hospital, Consulting Physician, Cook County Hospital; Consultant in Medicine to the Institute of Psychoanalysis, Chicago. Illustrated with 182 Engravings. Philadelphia: Lea & Febiger, 1944. Price $11.00.

This new edition of Dr. Portis' textbook on diseases of the digestive system gives a clear foundation for the understanding of the psychosomatic bearings of gastro-intestinal complaints. The war has given the gastro-enterogolist an opportunity to study the changes in young adults brought about by emotional stress, and these features are discussed by the contributors in connection with their sections of the book. The history of gastro-intestinal observations and studies is followed from the first papyri to the latest investigations. Diagnosis, prognosis, treatment are emphasized. This is a standard-sized textbook with approximately fifty contributors, rich in references, and orderly in workmanship and execution.

PLASTER OF PARIS TECHNIQUE. By Edwin O. Geckeler, M.D., Associate Professor of Orthopedic Surgery, and Chief of the Fracture Service, Hahnemann Medical College and Hospital, Philadelphia. Fellow of the American Academy of Orthopaedic Surgeons, Fellow of the American Association for the Surgery of Trauma, Diplomate of the American Board of Orthopaedic Surgery. Baltimore: The Williams & Wilkins Company, 1944. Price $3.00.

The use and application of plaster of Paris is fully described in this small, but well-illustrated volume. The study of means and materials for plaster of Paris dressings is given full attention, and the pitfalls in application of dressings are pointed out with reasons and means to avoid them. It is a most practical book, and a ready guide to satisfactory work.

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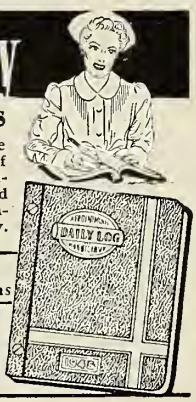
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THE DIAGNOSIS AND TREATMENT OF ACUTE MEDICAL DISORDERS. By Francis D. Murphy, M.D., F.A.C.P., Professor and Head of the Department of Medicine, Marquette University School of Medicine, and Clinical Director of the Milwaukee County General Hospital and Emergency Unit, Milwaukee, Wisconsin. Philadelphia: F. A. Davis Company, 1944.

As a teacher and clinical director Dr. Murphy has noted that chronic diseases are usually well handled by the average practitioner, while acute ones are a problem not so well understood. For that reason he has written this book with the aim to pass on to the practitioner diagnostic procedures and methods of treatment found helpful. Acute conditions come with such suddenness that the practitioner must have at hand a store of general knowledge, and be prepared to act promptly. Diagnosis and treatment are stressed in acute conditions as they occur, and for study purposes, they are considered as systems: The heart, metabolic disorders, the kidneys, the lungs, acute abdominal emergencies, acute infections, tropical diseases, and acute poisoning. A chapter is devoted to drugs used in these various conditions. There is a page devoted in tabular form to the uses of the sulfonamides, and another to their toxicity. This is a very practical book, full of ideas and experience-proved methods.

INTERNAL MEDICINE IN GENERAL PRACTICE. By Robert Pratt McCombs, Lieutenant, Medical Corps, United States Naval Reserve; Recently Instructor in Internal Medicine for the Statewide Postgraduate Program of the Tennessee State Medical Association. On leave of absence from the staffs of the Pennsylvania Hospital, the Abington Memorial Hospital and the Jefferson Medical College, Philadelphia. 694 pages with 114 illustrations. Philadelphia and London: W. B. Saunders Company. Price $7.00.

The methods of the internist are applied to general practice, including notes on the necessity of careful histories, simple but efficient clinical methods, and a careful evaluation of the diagnosis, avoiding the snap judgment, and thus saving much time for the doctor and the patient. The author is an officer in the Navy and the book carries a foreword by Admiral McIntire. It is well done, and a valuable book.

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INDEX TO VOLUME 43

AUTHOR'S INDEX

Aldrich, C. Anderson, 885
Alvarez, Walter C., 389
Applebaum, A. A., 989
Atchison, Russell M., 665

Baker, Abel J., 39
Barrett, C. D., 889

Cannon, Paul R., 323
Coggeshall, L. T., 662
Colvin, Leslie T., 138

DeKleine, William, 897
Downer, Ira G., 214
Ducey, Edward F., 38

Farbman, Aaron A., 141
Foerster, H. R., 307
Foster, L. Fernald, 8

Gariepy, Louis J., 665
Grego, J. Gregory, 401

Harkins, Henry N., 401
Himler, L. E., 564
Hirshfeld, John Winslow, 584
Hufford, A. Ray, 1076
Hufford, C. E., 989
Hunt, John F., 981

Jocz, Marion W., 577

Keane, William E., 232
Kennedy, R. H., 657
Kenny, Elizabeth, 673
Kerr, L. E., 889
Keyport, Claude R., 557, 883
Kleinschmidt, Earl E., 320
Kronfeld, Peter C., 209

Leader, Luther R., 777
Lichter, M. L., 138
Lillie, Harold I., 27
Long, Charles-Francis, 574

McQuarrie, Irvine, 492
Martin, Walter B., 483
Meakins, Jonathan C., 997
Menninger, William C., 1069
Mitchell, A. B., 779
Munson, Frederick T., 231
Musacchio, Frederick A., 392
Mussey, Robert D., 129

Ormsby, Oliver S., 315

Peck, Samuel M., 568
Petree, Paul A., 483
Pike, Melvin H., 581
Plass, E. D., 402
Pool, H. H., 406
Prendergast, John J., 577

Reimann, Hobart A., 147
Rowntree, Leonard G., 769

Saltzstein, Harry C., 145
Scholten, William, 142
Schumann, Edward A., 488
Schwartz, Louis Adrian, 219
Sisson, John M., 900
Smith, Clement A., 668
Solworth, Mohe H., 558
Souda, Andrew E., 401
Speed, Kellogg, 33

Whitehorn, John C., 395
Wilson, Thomas R., 129

Zinninger, Max M., 1082

CONTRIBUTED PAPERS

A

Abdominal palpation, An aid in. Aaron A. Farbman, M.D., 141

Abnormal uterine bleeding after middle age. Robert D. Mussey, M.D., and Thomas R. Wilson, M.D., 129

Address of Welcome. Claude R. Keyport, M.D., 557

Aid in abdominal palpation, An. Aaron A. Farbman, M.D., 141

Albuminuria, essential hypertension and nutritional deficiency, Suggested inquiry into possible relation between. William DeKleine, M.D., 809

Analysis of deaths occurring in Michigan from pneumonia (all forms). A. B. Mitchell, M.D., M.P.H., 779

Army health service, modern, What a, should be. Brigadier Jonathan C. Meakins, M.D., 997

Avitaminosis in dermatology and the value and limitations of the sulfa group in skin diseases. Oliver S. Ormsby, M.D., 315

B

Blindness, Preventable. Peter C. Kronfeld, M.D., 209

C

Calculi, large vesical, Management of. Ira G. Downer, M.D., 214

Casualties, War, in a general hospital in the U. S. A. Col. R. H. Kennedy, MC, AUS, 657

Certain observations on pains in the head of intranasal origin. Harold I. Lillie, M.D., 27

Children, Edema in. Irvine McQuarrie, M.D., 492

Children, The significance of a complete preventive medical program for. C. Anderson Aldrich, M.D., 885

Chordoma: Report of a case. William E. Keane, M.D., 232

Clinical, histopathological and inheritance factors in peroneal muscular atrophy (Charcot-Marie-Tooth type). Lt. Comdr. Louis Adrian Schwartz, 219

Congenital heart block. Leslie T. Colvin, M.D., and M. L. Lichter, M.D., 138

Criteria for employability of individuals with lung pathology. Charles-Francis Long, M.D., 574

D

Dermatitis of wartime industries in general practice. H. R. Foerster, M.D., 307

Dermatitis, Prevention of epidemics of, in industry, including dermatophytosis. Samuel M. Peck, M.D., 568

Dermatology, Avitaminosis in, and the value and limitations of the sulfa group in skin diseases. Oliver S. Ormsby, M.D., 315

Diagnosis, The gastroscope as an aid to. A Ray Hufford, M.D., 1076

Diphtheria outbreak, A small, in Sturgis. Frederick A. Musacchio, M.D., 392

E

Edema in children. Irvine McQuarrie, M.D., 492

Essential hypertension, albuminuria and nutritional deficiency, Suggested inquiry into possible relation between. William DeKleine, M.D., 897

Establishment of the first public health laboratory in the United States. Earl E. Kleinschmidt, M.D., Dr.P.H., 320

F

Federal plan for providing obstetric and pediatric care for wives and infants of servicemen, The. L. Fernald Foster, M.D., 8

Femur, Osteogenic sarcoma of upper third of. Harry C. Saltzstein, M.D., 145

Finger bandage, An interlocking, which needs no anchor. H. H. Pool, M.D., 406

Fractures, open, Treatment of. Kellogg Speed, M.D., 33

G

Gall-bladder disease, The surgical treatment of. Max M. Zinninger, M.D., 1082

Gastroscope as an aid to diagnosis, The. A. Ray Hufford, M.D., 1076

H

Head, Certain observations on pains in the, of intranasal origin. Harold I. Lillie, M.D., 27

Health needs of the nation as reflected by Selective Service, The. Colonel Leonard G. Rowntree, 769

Heart block, Congenital. Leslie T. Colvin, M.D., and M. L. Lichter, M.D., 138

I

Infection, Protein metabolism and resistance to. Paul R. Cannon, M.D., 323

Interlocking finger bandage which needs no anchor, An. H. H. Pool, M.D., 406

Interns, The neglected. Luther R. Leader, M.D., 777

Intussusception. Louis J. Gariepy, M.D., and Russell M. Atchison, M.D., 665

L

Lung pathology, Criteria for employability of individuals with. Charles-Francis Long, M.D., 574

M

Malaria: A current and postwar medical problem. L. T. Coggeshall, M.D., 662

Management of large vesical calculi. Ira. G. Downer, M.D., 214

Medicine, What the people of Michigan think of. John F. Hunt, 981

Mental health problems in industry, The psychiatric approach to. L. E. Himler, M.D., 564

Methods of personality study in relation to medical practice. John C. Whitehorn, M.D., 395

Muscular atrophy, peroneal (Charcot-Marie-Tooth type), Clinical, histopathological and inheritance factors in. Lt. Comdr. Louis Adrian Schwartz, 219

N

Neglected interns, The. Luther R. Leader, M.D., 777

Neuropsychiatry and the general practitioner. Col. William C. Menninger, MC, 1069

Newer trends in industrial sanitation. Mohe H. Solworth, 558

Nutritional deficiency, albuminuria and essential hypertension, Suggested inquiry in possible relation between. William DeKleine, M.D., 897

O

Obstetric and pediatric care for wives and infants of servicemen, The federal plan for providing. L. Fernald Foster, M.D., 8

Obstetrics, Wartime. E. D. Plass, M.D., 402

Ocular pathology due to organic compounds. Melvin H. Pike, M.D., 581

Office treatment of rectal disease. Andrew E. Souda, M.D., 501

Osteogenic sarcoma of upper third of femur. Harry C. Saltzstein, M.D., 145

P

Palindromic rheumatism (Hench's disease). J. Gregory Grego, M.D., and Henry N. Harkins, M.D., 401

Paresis, general, What price? William Scholten, M.D., 142

Peculiarities in the physiology of newborn patients. Clement A. Smith, M.D., 668

Penicillin in surgery. John Winslow Hirshfeld, M.D., 584

Personality study, Methods of, in relation to medical practice. John C. Whitehorn, M.D., 395

Pneumonia (all forms), Analysis of deaths occurring in Michigan from. A. B. Mitchell, M.D., M.P.H., 779

Pneumonia, Primary atypical. A. A. Applebaum, M.D., and C. E. Hufford, M.D., 989

Pneumonias, Primary atypical, of unknown cause: "virus" or "viral" pneumonias. Hobart A. Reimann, M.D., 147

Poliomyelitis: Contrast between the Kenny and orthodox concepts with results of treatment. Elizabeth Kenny, 673

Postpartum sterilization. Edward A. Schumann, M.D., 488

Practitioner, general, Neuropsychiatry and the. Col. William C. Menninger, MC, 1069

Pregnancy, Tubal. John M. Sisson, M.D., 900

Preventable blindness. Peter C. Kronfeld, M.D., 209

Prevention of epidemics of dermatitis in industry including dermatophytosis. Samuel M. Peck, M.D., 568

Preventive medical program for children, complete, The significance of a. C. Anderson Aldrich, M.D., 885

Primary atypical pneumonia. A. A. Applebaum, M.D., and C. E. Hufford, M.D., 989

Primary atypical pneumonias of unknown cause: "virus" or "viral" pneumonias. Hobart A. Reimann, M.D., 147

Problem of the mild psychoneurotic in the army, The. Colonel Walter B. Martin, M.C., and Lt. Colonel Paul A. Petree, MC, 483

Prognosis. Abel J. Baker, M.D., 38

Protein metabolism and resistance to infection. Paul R. Cannon, M.D., 323

Psychiatric approach to current mental health problems in industry, The. L. E. Himler, M.D., 564
Psychoneurotic, mild, The problem of the, in the army. Colonel Walter B. Martin, MC, and Lt. Colonel Paul A. Petree, MC, 483
Public health laboratory, first, Establishment of the, in the United States. Earl E. Kleinschmidt, M.D., Dr. P. H., 320

R

Reconditioning problems of disabled veterans. Marion W. Jocz, M.D., and John J. Prendergast, M.D., 577
Rectal disease, Office treatment of. Andrew E. Souda, M.D., 501
Rheumatism, Palindromic (Hench's disease). J. Gregory Grego, M.D., and Henry N. Harkins, M.D., 401
Rhinolith in a child. Frederick T. Munson, M.D., 231

S

Sanitation, industrial, Newer trends in. Mohe H. Solworth, 558
Sarcoma, Osteogenic, of upper third of femur. Harry C. Saltzstein, M.D., 145
Selective Service, The health needs of the nation as reflected by. Colonel Leonard G. Rowntree, 769
Significance of a complete preventive medical program for children, The. C. Anderson Aldrich, M.D., 885
Skin diseases, Avitaminosis in dermatology and the value and limitations of the sulfa group in. Oliver S. Ormsby, M.D., 315
Small diphtheria outbreak in Sturgis, A. Frederick A. Musacchio, M.D., 392
Small unrecognized strokes. Walter C. Alvarez, M.D., 389
Sterilization, Postpartum. Edward A. Schumann, M.D., 488
Strokes, Small unrecognized. Walter C. Alvarez, M.D., 389
Suggested inquiry into possible relation between albuminuria, essential hypertension and nutritional deficiency. William DeKleine, M.D., 809
Surgery, Penicillin in. John Winslow Hirschfeld, M.D., 584
Surgical treatment of gall-bladder disease, The. Max M. Zinninger, M.D., 1082
Survey of 180 cases of syphilis in a suburban and rural community, Ingham County, Michigan. C. D. Barrett, M.D., and L. E. Kerr, M.D., 889
Syphilis, A survey of 180 cases of, in a suburban and rural community, Ingham County, Michigan. C. D. Barrett, M.D., and L. E. Kerr, M.D., 889

T

Treatment of open fractures. Kellogg Speed, M.D., 33
Tubal pregnancy. John M. Sisson, M.D., 900
Tularemia. Edward F. Ducey, M.D., 38

U

Uterine bleeding, Abnormal, after middle age. Robert D. Mussey, M.D., and Thomas R. Wilson, M.D., 129

V

Veterans, disabled, Reconditioning problems for. Marion W. Jocz, M.D., and John J. Prendergast, M.D., 577

W

War casualties in a general hospital in the U. S. A. Col. R. H. Kennedy, MC, AUS, 657
Wartime industries, Dermatitis of, in general practice. H. R. Foerster, M.D., 307
Wartime obstetrics. E. D. Plass, M.D., 402
What a modern army health service should be. Brigadier Jonathan C. Meakins, M.D., 997
What it means to be a doctor. Claude R. Keyport, M.D., 883
What price general paresis? William Scholten, M.D., 142
What the people of Michigan think of medicine. John F. Hunt, 981

DEPARTMENT INDEX

Communications

Brunson, Eugene T., 165
Foster, L. Fernald, 714
McIntyre, J. E., 166
Mooney, Herbert R., 713
Moyer, H. Allen, 48
Mutual Benefit Health & Accident Assn., 715
Nowicki, Captain J. A., 608
Schorr, Robert L., 48
Titus, Paul, 331
Umphrey, C. E., 714

County and Personal Activities

County and personal activities, 84, 167, 260, 343, 437, 516, 610, 708, 818, 920, 1016, 1113

The Doctor's Library

American Medical Association: Annual reprint of the reports of the Council on Pharmacy and Chemistry of the American Medical Association, 935
American Medical Association: New and nonofficial remedies, 931
American Medical Association, Council on Foods and Nutrition: Handbook of nutrition, 445
American Soviet Medical Society: American review of Soviet medicine, 174
Association for Research in Nervous and Mental Diseases, Proceedings of the: Pain, 266
Barach, Alvan L.: Principles and practices of inhalational therapy, 832
Beardwood, Joseph T., and Kelly, Herbert T.: Simplified diabetic management, 1022
Beck, Samuel J.: Rorschach's test, 525
Bell, E. T.: A textbook of pathology, 524
Bellows, John G.: Cataract and anomalies of the lens, 932
Bockus, Henry L.: Gastroenterology (In three volumes) Volume II, 444
Brown, Anson Lee: A new test for syphilis, 526
Bunch, C. C.: Clinical audiometry, 172
Carrington, William J.: Safe convoy, the expectant mother's handbook, 445
Cecil, Russell L.: A textbook of medicine, 267
Christopher, Frederick: Minor surgery, 442

Clinics: A symposium on war medicine, presented at the 51st Annual Meeting of the Association of Military Surgeons, 526
Colestock, Claire: Fundamental exercises for physical fitness, 444
Colwell Publishing Co.: Dr. Colwell's daily log for physicians, 1026
Cowdry, E. V.: Microscopic technique in biology and medicine, 90
Curran, Desmond: Psychological medicine, 264
Dattner, Bernhard; Thomas, Evan W., and Wexler, Gertrude: The management of neurosyphilis, 717
Davis, John Eisele: Principles and practice of rehabilitation, 173
Davison, Forrest Ramon: Synopsis of materia medica, toxicology and pharmacology, 525
Davison, Wilburt C.: The compleat pediatrician, 264
Davson, Hugh, and Danielli, James Frederic: The permeability of natural membranes, 349
de Lorimier, Alfred A.: The arthropathies, 266
Deutsch, Helene: The psychology of women, 717
Dickson, Frank D., and Diveley, Rex L.: Functional disorders of the foot, 718
Dorland, W. A. Newman: The American illustrated medical dictionary, 622
Draper, George; Dupertuis, C. W., and Caughey, J. L., Jr.: Human constitution in clinical medicine, 442
Erich, John B., and Austin, Louie T.: Traumatic injuries of facial bones, 350
Everett, Houston S.: Gynecological and obstetrical urology, 1123
Feinberg, Samuel M., and Durham, Oran C. (collaborator): Allergy in practice, 719
Fetterman, Joseph L.: The mind of the injured man, 89
Flagg, Paluel J.: The art of anesthesia, 1024
Forbus, Wiley D.: Reaction to injury, 269
Fray, W. Kelsey, et al.: The dental treatment maxillofacial injuries with supplementary material on cases and techniques, 928
Funsten, Robert V., and Calderwood, Carmelita: Orthopedic nursing, 935
Geckeler, Edwin O.: Fractures and dislocations for practitioners, 266
Geckeler, Edwin O.: Plaster-of-Paris technique, 1123
Glasser, Otto: Medical physics, 444
Gradwohl, R. H. A.: Clinical laboratory methods and diagnosis, 268
Greenblatt, Robert B.: Office endocrinology, 718
Gunther, Carl E. M.: Practical malaria control, 619
Gurd, Fraser B., and Ackman, F. Douglas: Technique in trauma, planned timing in the treatment of wounds, including burns, 834
Harkins, Henry N.: Quarterly review of surgery, 525
Hawley, Estelle E., and Carden, Grace: The art and science of nutrition, 620
Heuer, George J.: The treatment of peptic ulcer, based upon ten years' experience at the New York hospital, 832
Hewitt, Richard M., et al. (editors): Collected papers of the Mayo Clinic and the Mayo Foundation, 931
Hoffman, Jacob: Female endocrinology, 619
Hollender, Abraham R.: Office treatment of the nose, throat and ear, 349
Hotchkiss, Robert Sherman: Fertility in men, 934
International Bulletin: Poliomyelitis (Rosenow), 832
Judovich, Bernard, and Bates, William: Segmental neuralgia in painful syndromes, 1023
Kay-Scott, C.: Life is too short, 90
Kovacs, Richard: A manual of physical therapy, 622
Lewin, Philip: Backache and sciatic neuritis, 350
Lichtwitz, Leopold: Pathology and therapy of rheumatic fever, 267
Lindner, Robert M.: Rebel without a cause, 933
Litzenberg, Jennings C.: Synopsis of obstetrics, 444
Lowsley, Oswald Swinney: Clinical urology, 1122
McCombs, Robert Pratt: Internal medicine in general practice, 1124
MacBryde, Cyril M., et al: The analysis and interpretation of symptoms, 834
Manson-Bahr, Sir Philip: Synopsis of tropical medicine, 89
May, Charles H.: Manual of the diseases of the eye, 525
Mayer, Edgar: Radiation and climatic therapy of chronic pulmonary diseases, 934
Michigan State Medical Society: Cancer, a manual for physicians, 443, 1025
Moll, Aristides A.: Aesculapius in Latin America, 718
Murphy, Francis D.: The diagnosis and treatment of acute medical disorders, 1124
Novak, Emil: Textbook of gynecology, 1122
Orr, Thomas G.: Operations of general surgery, 1121
Painter, Charles E. (editor): Industrial and orthopedic surgery, 349
Portis, Sidney A.: Diseases of the digestive system, 1123
Pullen, Roscoe L.: Medical diagnosis, 931
Rehberger, George F. (compiler): Quick reference book for medicine and surgery, 932
Ritter, John Franklin: Nascent endocrine therapy, 349
Robertson, H. E.: Hydronephrosis and pyelitis of pregnancy, 928
Rolleston, Humphrey, and Moncrieff, Alan: Minor surgery, 930
Rowe, Albert H.: Elimination diets and patients' allergies, 620
Sadler, William S.: Prescription for permanent peace, 1121
Schwartz, Jacob Hyams: Elements of medical mycology, 264
Seiffert, Gustav: Virus diseases in man, animal and plant, 621
Siegler, Samuel L.: Fertility in women, 934
Simons, James Stevens, et al: Global epidemiology, 1022
Sladen, Frank J.: Psychiatry and the war, 930
Smith, Frederick C.: Sulfonamide therapy in medical practice, 619
Solomon, Harry S., and Yakovlev, Paul I. (editors): Manual of military neuropsychiatry, 1121
Southmayd, Henry J.: Small community hospitals, 717
Spaeth, Edmund B.: The principles and practice of ophthalmic surgery, 930
Steinberg, Bernhard: Infections of the peritoneum, 717
Stern, Francis: Applied dietetics, 443
Strecker, Edward A.: Fundamentals of psychiatry, 834
Thoma, Kurt H.: Oral pathology, 443
Thorek, Max: A surgeon's world, 92
Thorek, Max: Surgical errors and safeguards, 174
Tobias, Norman: Essentials of dermatology, 524
Truslow, Walter: Body poise, 173
Turner, C. E.: Personal and community health, 172
Weiss, Samuel: Clinical lectures on gall bladder, 524
Zoethout, William D., and Tuttle, W. W.: Textbook of physiology, 92

Editorial Comment

Backward step, A, 188
Mene, mene, tekel upharsin, 188
Opportunity for distinguished service, A, 190

Editorial Department

Attention! (Amendment, Article VI, Constitution of State of Michigan), 592
Bar Association condemns S1161, 331
Biddle, Andrew P., 782
Bureaucrats, The, 507
Cancer manual, 153
Continuing medical education, 784
Contributions to MSMS Foundation for postgraduate medical education, 329
Developing a program? 152
Doctor and the public, The, 44
Doctors for the future, 906
Doctors for the postwar period, 591
EMIC, 329
Evolution and bureaucracy, 152
Fifth war loan, 506
Government medicine again, 1090
Have we a program? 46, 236
History repeats, 785
Industrial medicine and surgery, 592
Medical education, 234
Medical evolution, 234
Michigan Health Council, The, 409
"Michigan's Medical Plan Sets Pace for the Nation," 1090
Michigan public opinion survey, The, 1091
National survey on medical services, 330
New year, The, 44
Official appointees, 236
Pays 20 per cent proration, 506
Physical medicine, 507
Plans for the future, 329
Political medicine, 907, 1092
Postgraduate conference on war medicine—1944, 681, 782
Postwar plans, 590
President, president-elect, council and other elections, 908
Public opinion, 680
Radio and patent medicines, 591
Regimented control, 329
Replies to criticism, 1005
Servicemen's readjustment act of 1944, The, 782
Seventy-ninth annual session, The, 1005
Success of Michigan Medical Service, The, 331
This time a ray of understanding, 785
Wagner-Murray-Dingell Bill, 409
We need a book, 408
We still need a book, 907
What the public thinks of us, 1004

In Memoriam

Allen, James U., 704
Ash, Charles W., 434
Bahman, Gordon H., 434
Baker, Charles Harper, 704
Barbour, Herbert V., 514
Batts, Martin, Jr., 704
Berman, Harry S., 434
Biddle, Andrew P., 830
Bohn, Frank P., 616
Bower, A. J., 916
Brooks, Ervin D., 616
Brown, Horatio Alford, 162
Burns, John Thomas, 704
Chenik, Ferdinand, 916
Childs, Lloyd H., 1104
Colignon, Constance M., 434
Collins, Edmund F., 704
Davenport, Carroll S., 514
Dell, Ellsworth E., 162
DeWitt, Stuart Lloyd, 514
Drolshagen, Elmer A., 435
Force, William Howard, 514
Geenen, C. J., 830
Geerlings, Lewis J., 616
George, A. W., 918
Gillett, Orla H., 830
Gilpin, John H., 704
Hawken, William C., 616
Heavenrich, Theodore F., 616
Keefe, John P., 916
Kellogg, John Harvey, 162
Kelly, Frank A., 162
Laird, Robert C., 1104
Landon, Charles C., 435
Lash, Michael William, 514
LeFevre, George Louis, 435
Long, Harry W., 617
Lynch, Edward J., 617
MacGregor, James C., 435
Martin, William C., 1104
Meengs, Jacob Earl, 436
Mooney, Charles A., 617
Morse, Bertram W., 1104
Moyer, H. Allen, 163
Murphy, John T., 704
Murtha, A. V., 918
Palmerlee, George H., 436
Peterson, Eryl S., 163
Reed, Wilbur F., 704
Repp, William A., 706
Scheurer, Peter Arthur, 617
Scott, James W., 706
Sears, Harley A., 436
Seliady, Joseph Eugene, 434
Sheridan, Charles R., 1106
Skully, G. A., 916
Sleight, Raymond Duane, 163
Smith, William A., 1106
Spencer, Clayton Myron, 436
Spohn, U. G., 830
Stabile, Vito V., 1104
Swartz, John N., 1106
Tuthill, Frank Scott, 514
Walker, Robert J., 436
Warford, J. T., 830
Weinburgh, Harry B., 706
Wood, Arthur C., 514
Wright, John Mill, 514
Young, Clifford Caudy, 617

Michigan's Department of Health

Accidents cost fewer lives in state in 1943, 256
Alvarez, Doctor, in navy, 816
Birth record demand drops from 1942 peak, 80
Blood plasma is sent to ten Michigan cities, 80
Colds and pneumonia reported on increase, 80
Communicable diseases, 910
Demand is decreasing for records of births, 256
Education program for dentists, 698
EMIC Advisory Committee, 698
Farm workers need tetanus toxoid, 430
Fever treatment for neuropsychiatric children, 698
Fluorine experiment, 910
Increase of venereal disease, 698
Meningitis among newborn traced to Salmonella panama, 430
Meningitis, measles epidemics are likely, 80
Michigan blood plasma program, 816
Michigan deaths due to cancer, 430
Minor changes voted in control measures, 257
Mosquito survey, 698
Moyer, H. Allen, 158
New diagnostic service for dentists, 910
New diarrhea and enteritis control service offered, 430
New record in births will be set in 1943, 80
Penicillin distribution, 604
Pine Crest Sanatorium, 604
Pollen survey, 910
Rapid treatment center, 910
Salmonella panama, 604
Sanatoria heads plan closer co-operation, 256
Seven diseases above seven year median, 430
Sharp rise is noted in venereal diseases, 158
State labs to handle paratyphoid cultures, 256
Statewide plasma program in operation, 430
Toll in motor traffic is lowest since 1924, 257
Tuberculosis claims fewer lives in 1943, 256
Tuberculous veterans reported, 698
V-D rapid treatment, 604
Warning on tularemia issued by department, 80
X-ray unit will visit four state colleges, 256
Year in public health is largely favorable, 158

Michigan Medical Service

Annual meeting, 108

Michigan State Medical Society

Advisory Committee to Woman's Auxiliary, Annual report, 599
Beaumont Memorial Committee, Annual report, 599
Cancer Control Committee, Annual report, 599
Child Welfare Committee, Annual report, 600
Council, Annual report, 808
Council, Annual session, 244, 332
Delegates to AMA, Annual report, 810
Distribution of Medical Care Committee, and Temporary Committee of the Michigan State Medical Socity and the UAW-CIO, Annual report, 685
Ethics Committee, Annual report, 599
Heart and Degenerative Diseases Committee, Annual report, 688
Industrial Health Committee, Annual report, 599
Iodized Salt Committee, Annual report, 599
Joint Committee on V. D. Control of the State Bar of Michigan and the Michigan State Medical Society, Annual report, 601
Legislative Committee, Annual report, 600
MSMS Representatives to the Joint Committee on Health Education, Annual report, 684
Maternal Health Committee, Annual report, 684
Medical-Legal Committee, Annual report, 812
Mental Hygiene Committee, Annual report, 812
Nurses Training Schools Committee, Annual report, 600
Official call, 593
Past presidents, 682
Postgraduate Medical Education Committee, Annual report, 685
Prelicensure Medical Education Committee, Annual report, 685
Preventive Medicine Committee, Annual report, 684
Proceedings of House of Delegates, 1943 (second installment), 49
Proceedings of House of Delegates, 1944 (first installment), 1093
Procurement and Assignment Committee, Annual report, 689
Program—79th annual session, 787
Proposed amendments to constitution and by-laws, 598, 812
Public Relations Committee, Annual report, 688
Roster, 410, 538, 636
Technical exhibits, annual meeting, 690
Tuberculosis Control Committee, Annual report, 688
Radio Committee, Annual report, 687
Venereal Disease Control Committee, Annual report, 601

Miscellaneous

Biddle—Resolution re Dr. Andrew P., 904
County secretaries conference has large attendance, 192
County secretaries conference in Grand Rapids, 1012
Credit is due, 956
DeKleine, William, M.D.—Michigan's new Commissioner of Health, 280
Detroit is host to Association of American Medical Colleges, 850
Do you want your social security tax doubled? 368
Echoes of 1944 war conference, 952
Federal subsidies, 462
General Practice:
The general practitioner viewpoint. Luther W. Day, M.D., 948
Medical industrial conference, 358
Michigan doctors of medicine in military service, 237, 282
Michigan Health Council, 1006
Michigan Physicians Committee organized, 1010
Michigan postgraduate program for graduates in medicine, 736
Political medicine—The multiple cost of social security, 106
Political medicine, 366
Postgraduate industrial medical and surgical conference, 255
Recent opinions of Michigan's Attorney General, 14
Report on special session of the Michigan legislature, 1944, 280

Socialism and national welfare. Claude R. Keyport, M.D., 458
State medicine—Proposed constitutional amendment, 944
What the people think of medicine, 360

Political Medicine

Blind and deaf, The, 634
Britain's new health plan, 534
Commissions for male nurses, 634
New taxes, 536
Resolution Committee meets, 534
Seeing-eye dogs for veterans, 634
Shocking reports on health in U. S. given to senators—a "flabby, ailing nation." Lansing Warren, 866
Too much sickness insurance, not enough health insurance, 536
Transfer of health functions of Department of Labor to U.S.P.H.S., 632
Wagner-Murray-Dingell outdone, 632

President's Page

Biddle, Andrew P., endows postgraduate medicine, 1003
Billions and bureaus, 505
Free enterprise in medicine, 151
Great principles must be fought for—to be preserved, 905
Is there another side to medicine? 589
Keep the home fires burning, 407
MSMS committees, 327
No need for compulsion here, 235
No personal freedom, 45
Our medical veterans' readjustment program, 1089
Your September vacation, 679

War Bulletins

36th General Hospital, 854
1194 U.S. soldiers are amputation cases, 364
Accelerated instruction schedule at Wayne University, 12
Army ends its doctor "draft," Navy's goes on, 1040
Army Surgeon General reports falling death rate from disease and wounds, 634
ASTP program to continue, 118
Blood plasma reserves, 120
Doctor shortage pays off, 1040
Federal plan for providing obstetric and pediatric care for wives and infants of servicemen, The. L. Fernald Foster, M.D., 8
Four thousand army nurses needed immediately, 856
Hospitals staffed by German doctors opened in Oklahoma, 856
Important to doctors returning from medical corps service, 1040
Is the federal social security board intellectually honest? 118
Malaria mosquito survey of southern Michigan. Curtis W. Sabrosky, 456
Medical aid to vets. James Marlow, 942
Medical students, 186
Medical treatment, U. S. Army personnel, 186
Michigan flight surgeon receives medal, 854
Progress in chest surgery, 1040
Reorganization of the Office of the Surgeon General, The, 854
Repairing spectacles at the front, 856
Report of civilian eye, ear, nose and throat specialist work on induction board, U. S. Army, Detroit, Michigan, 538
Requirements listed for Sanitary Corps officers, 856
Separations from military service, 1040
Soldier death rate under 1917-18, 364
Surgical operating trucks take hospital to wounded soldiers, 854
Surgical teams work all night under fire, 120
Testimonial to Michigan medical men in military service, 942
Time is now, The, 186
Veterans' rehabilitation, 538
Waivers of physical defects, 120
Wartime graduate medical meetings, 122
Whole blood program of the Surgeon General, 856

Woman's Auxiliary

Woman's Auxiliary, 82, 160, 258, 342, 432, 606, 700, 912, 1014, 1108

You and Your Business

1945 Postgraduate conference on war medicine, The, 1103
Additional funds for EMIC program, 510
Administrative and professional problems of medical practice in the hospital, 252
A F of L expresses itself on bureaucratic domination, 512
AMA opens Washington, D. C., office, 428
American Board of Obstetrics and Gynecology, 696
American Board of Ophthalmology, 47
American Hospital Association names two new council secretaries, 602
Association of American Medical Colleges, 728
Basic Science Board of Examiners, 47
Beaumont gavel, The, 730
Cancer education in high schools, 252
Clinic Day, Fort Custer, June 21, 429
Collecting blood for plasma, 156
College of Medicine, Wayne University, graduates fifty-eight doctors, 47
Comedy a la Murray-Wagner-Dingell, 253
Declaration of medical policies, 154
Deferment of premedical students, 728
Detroit Institute of Cancer Research, 696
Detroit Medical Center, 602
Dispensing of vitamins, camphorated oil and boric acid, 428
Don't cash strangers' checks, 512
Dues and assessments, 1944, 428
EMIC program, 428
EMIC program—pure federal medicine, 726
Fee splitting, 864
Fees and billing under Afflicted Child Act, 428
Foot in the door, The, 510
Health insurance for Canada, 428
Income tax withholding requirements, 1103
MSMS radio hour over WJR, 429
Maternity mortality study in Michigan, 730
Measures for control of poliomyelitis, 864
Medical directories, 1103
Medicine or socialized medicine, 602

Meningitis in Michigan, 47
Michigan Health Council, 728
Michigan's intangibles tax, 864
Michigan Medical Service, 510
Migrant workers, 512
National Foundation for the Care of Advanced Cancer Patients, 602
Portable units for tuberculosis surveys, 860
Practice of medicine by hospitals, 726
Shortage of physicians, 602
Sickness insurance for railroad workers, 864
Social medicine topic discussed, 253
Social security, 252
Synthetic quinine, 510
Voluntary health plans in California, 47
Wagner-Murray-Dingell Bills, 47
Why speed up premedical education? 341

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